

Notes

Toward an Ohio Natural Death Act: The Need for Living Will Legislation

I. INTRODUCTION

Ohio's physicians presently face an intractable legal problem: under what circumstances may a physician order the application or discontinuance of life support systems¹ for a terminally ill² patient without incurring civil or criminal liability? Ohio's terminally ill patients face the concomitant problem: how may they best ensure that a physician will effectuate their intent to use or not use life support systems? The argument presented by this Note contends that Ohio case law provides insufficient solutions to the foregoing problems and, more specifically, that the Ohio General Assembly should substantially supplant the case law with legislation similar to The Rights of the Terminally Ill Act as proffered by the National Conference of Commissioners on Uniform State Laws (NCCUSL).³

II. THE OHIO PRECEDENT

A. Leach I: *Privacy and the Right to Remove*

Both the Ohio Supreme Court and the Ohio General Assembly have remained conspicuously silent on the topics of the use of life support systems and the treatment choices available to the terminally ill. Consequently, Ohio's physicians and attorneys must turn to the state's lower courts when attempting to determine the rights and responsibilities of physicians and patients facing these particular treatment problems. The Summit County Court of Common Pleas, Probate Division, rendered the first decision on point in its 1980 opinion, *Leach v. Akron General Medical Center* (Leach I).⁴ Marie Leach, a seventy year old woman diagnosed as suffering from amyotrophic lateral sclerosis (a degenerative neuro-muscular disorder), incurred a cardiac arrest on July 29, 1980 while hospitalized.⁵ Though physicians restored her heartbeat, her condition prompted physicians to place Mrs. Leach on a life support system. Mrs. Leach had lapsed into a chronic vegetative state. Neurological testimony, adduced at trial, unanimously confirmed that Mrs. Leach was suffering from irreversible brain

1. A life support system is defined as a respirator which assists or compels respiration, a nasogastro tube which aids in the feeding process, and a catheter which dispels waste. *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 3, 426 N.E.2d 809, 810 (C.P. Summit Co. P. Div. 1980).

2. This Note addresses only the rights of patients who have been medically diagnosed as terminally ill. Living will statutes typically define terminal illness as a condition from which there can be no recovery and because of which death is imminent. *See, e.g.*, VA. CODE § 54-325.8:2 (Supp. 1985).

3. THE RIGHTS OF THE TERMINALLY ILL ACT §§ 1-12 (Tent. Draft 1984).

4. 68 Ohio Misc. 1, 426 N.E.2d 809 (C.P. Summit Co. P. Div. 1980).

5. *Id.* at 2, 426 N.E.2d at 810.

damage.⁶ Though not brain dead, Mrs. Leach was completely without cognitive powers, and the chances of restoring her to a cognitive or sapient state were described as "highly unlikely."⁷ Upon successfully seeking appointment as Mrs. Leach's guardian, Mr. Leach instituted an action to compel discontinuance of Mrs. Leach's life support system.⁸

Faced with this set of facts, the *Leach I* court followed the lead of several other states in empowering Mr. Leach, as the patient's guardian, to direct the withdrawal of Mrs. Leach's respirator.⁹ Drawing from the constitutional analysis of *In re Quinlan*,¹⁰ the court held that the right to privacy "guarantees to an incurably, terminally ill person, who is in a permanent, vegetative state, the right to decide future medical treatment."¹¹ The *Leach I* court granted Mrs. Leach's guardian the authority to decide for her. However, the court enabled her guardian to direct discontinuance only upon the finding of the fact "that Edna Marie Leach, in her present physical condition, if competent, would elect not to be placed on or continued on life supports"¹² In support of permitting a guardian to make treatment decisions for the presently comatose ward, the court commented: "'We cannot but emphasize that there must exist a mechanism to ascertain and to implement the patient's consent. To deny the exercise because the patient is unconscious is to deny the right.'"¹³

Almost perfunctorily, the court dismissed as less than compelling the alleged state interests in maintaining Mrs. Leach's life supports. Though the defendants posited the preservation of life as a compelling state interest, the court "could see no possible benefit to the state by briefly extending the minimal life of an incurably ill,

6. *Id.* at 4, 426 N.E.2d at 811.

7. *Id.* at 5, 426 N.E.2d at 811 (testimony of Dr. Richard J. Lederman, a neurologist). At this point, it may be helpful to distinguish Mrs. Leach's chronic vegetative state from brain death. Death, as presently defined in Ohio (the definitional statute was not yet in force at the time *Leach I* was decided), occurs when an individual "has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the brain . . . as determined in accordance with accepted medical standards." OHIO REV. CODE ANN. § 2108.30 (Page Supp. 1984). Commonly, the Harvard Test is the standard utilized: 1) lack of reactivity and response to painful stimuli; 2) no spontaneous movements or breathing; 3) no reflexes; and 4) a flat EEG (all tests to be repeated twenty-four hours later with the same results). *Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death Report: A Definition of "Irreversible Coma,"* in 1 THE DILEMMAS OF EUTHANASIA 161-63 (J. Behnke & S. Bok eds. 1975). In its final paragraph, the Ohio statute absolves physicians and those under their direction from civil or criminal liability for acting in good faith reliance on a physician's determination of brain death. OHIO REV. CODE ANN. § 2108.30 (Page Supp. 1984). In short, since a physician may remove life support systems without fear of liability, the brain dead patient poses no significant legal problems.

8. *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 3, 426 N.E.2d 809, 811 (C.P. Summit Co. P. Div. 1980).

9. *Id.* at 12, 426 N.E.2d at 816. For cases from other states allowing a patient's guardian to direct the withdrawal of the patient's respirator, see *Satz v. Perlmutter*, 379 So. 2d 359 (Fla. 1980); *In re Spring*, 405 N.E.2d 115 (Mass. 1980); *Supt. Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied sub nom., 429 U.S. 922 (1976); *In re Eichner*, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980), modified sub nom. *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

10. 70 N.J. 10, 355 A.2d 647, cert. denied sub nom., 429 U.S. 922 (1976).

11. *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 12, 426 N.E.2d 809, 816 (C.P. Summit Co. P. Div. 1980). See generally *Roe v. Wade*, 410 U.S. 113 (1973); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (cases dealing with the right to privacy).

12. *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 5, 426 N.E.2d 809, 812 (C.P. Summit Co. P. Div. 1980). The court found Mrs. Leach would have so elected. See *infra* text accompanying notes 23-24.

13. *Id.* at 8, 426 N.E.2d at 813 (quoting *In re Eichner*, 73 A.D.2d 431, 470, 426 N.Y.S.2d 517, 546 (1980), modified sub nom. *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981)).

seventy-year-old, semi-comatose woman.”¹⁴ The court concluded the interest in protecting third parties was insignificant, noting Mrs. Leach’s husband and children approved seeking life support removal.¹⁵ The court further held that discontinuing Mrs. Leach’s life supports would not impugn the ethical integrity of the medical profession, finding discontinuance consistent “with the current state of medical ethics.”¹⁶ Finally, the court determined that Mrs. Leach’s treatment decision did not implicate the state’s interest in preventing suicide: “Suicide requires a specific intent to die. Withdrawal of a respirator evinces only an intent to forego extraordinary measures, and allows the processes of nature to run their course.”¹⁷ The court concluded “that no state interest, either legal or societal, exists to the degree necessary to outweigh the Constitutional right of Edna Marie Leach . . . to choose medical treatment.”¹⁸

B. Leach I: *Uncertainty is the Rule*

Leach I, though a thoughtful constitutional approach sound on its facts, suffers from inherent limitations which render it insufficient in its ability to provide adequate rules with which to govern the various life support fact patterns.

First, *Leach I* is quite simply a trial court decision. Though a case of first impression persuasively reasoned, *Leach I* is not binding precedent on any court in the state. Until the Ohio Supreme Court or the General Assembly addresses the issues raised in *Leach I*, uncertainty will remain the rule.

Second, *Leach I* addresses only the rights of a limited patient class: patients who are terminally ill, comatose, and currently maintained by a life support system. By way of inference one might argue that *competent*, terminally ill patients attached to life supports might also successfully seek probate court intervention to secure removal of a respirator. But nowhere in the opinion is this fact pattern considered. Moreover, *Leach I* fails to address the treatment options of the terminally ill patient (whether competent or comatose) before life supports are actually applied. May a patient refuse life supports prior to application, or must he or she wait, seeking judicial intervention only after application? *Leach I* offers no answer.

Third, *Leach I* inadequately safeguards the rights of the patient class to which it applies: terminally ill, comatose patients currently maintained on life supports. *Leach I* implicitly requires a patient or his guardian to repair to the probate court for an order of discontinuance.¹⁹ Physicians, even those previously disposed toward discontinuance in hopeless cases, may now fear to order life support removal without first securing a probate court order. Consequently, *Leach I* may engender increased probate court litigation as physicians seek judicial support for medical orders they may have made previously as a matter of course. Furthermore, *Leach I* specifically

14. *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 9, 426 N.E.2d 809, 814 (C.P. Summit Co. P. Div. 1980).

15. *Id.* at 9–10, 426 N.E.2d at 814.

16. *Id.* at 10, 426 N.E.2d at 815.

17. *Id.*

18. *Id.*

19. *Id.* at 12–13, 426 N.E.2d at 816.

limits the scope of its decree to its particular facts,²⁰ drawing into question the applicability of these procedures even to future similarly situated litigants.²¹ The court not only limited the decree to particular facts, but the order itself permitted only discontinuance of Mrs. Leach's respirator.²² Are the other components of the life support system not to be removed in any case? One may only answer with speculation.

Last, *Leach I* seems to establish a requisite fact finding that may prove to deny many terminally ill, comatose patients the alternative of judicial relief. As part of the court's listed findings of fact and conclusions of law, the court held that "Edna Marie Leach, if competent, would elect not to be placed on life supports."²³ Testimony of Mrs. Leach's previous conversations with friends and relatives regarding her desire not to be maintained on life supports prompted the court's finding.²⁴ Certainly this fact finding helps to ensure that the patient's intent is effectuated, but if this fact finding is a requisite to life support removal, the intent of other patients may be subverted. For example, consider under the *Leach I* rule the chronic vegetative patient who had not previously expressed strong desires regarding the use of life support systems. Should this patient be beyond judicial aid in securing the discontinuance of life supports? Under *Leach I* this may be the case: no determination of prior intent, no discontinuance.

Karen Quinlan had made no determinative statements regarding the use or nonuse of life supports before she slipped into an irreversible coma.²⁵ It seems likely that her guardian would have been incapable of establishing that Karen "if competent, would elect not to be placed on life supports."²⁶ Ironically, under *Leach I*, a case which openly borrows from the *Quinlan* decision, Karen Quinlan's guardian in all likelihood would have been unsuccessful in securing removal of Ms. Quinlan's life support system.

20. Note, *Right to Privacy: Removal of Life-Support Systems*, 16 AKRON L. REV. 162, 169 (1982).

21. *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 12, 426 N.E.2d 809, 816 (C.P. Summit Co. P. Div. 1980). The *Leach I* court required the following procedures to be followed in carrying out its order of discontinuation:

- 1) A licensed physician and neurologist selected by the guardian must examine and then certify that Edna Marie Leach continues in a permanent vegetative state, and that there is no reasonable medical possibility that she will regain any sapient or cognitive function.
- 2) A forty-eight hour notice of the examination must be given to the Summit County Coroner and Prosecutor. The Coroner's and Prosecutor's Office may have a witness or witnesses present at the examination.
- 3) When the examination is complete, a forty-eight hour notice of the act of discontinuation must be given to the Summit County Coroner's and Prosecutor's Office.

Id. For an example of postorder procedures drafted to apply to future similarly situated litigants, see *In re Quinlan*, 70 N.J. 10, 54-55, 355 A.2d 647, 671-72, *cert. denied sub nom.*, 429 U.S. 922 (1976).

22. *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 13, 426 N.E.2d 809, 816 (C.P. Summit Co. P. Div. 1980).

23. *Id.* at 5, 12, 426 N.E.2d at 812, 816.

24. *Id.* at 4, 426 N.E.2d at 811.

25. *In re Quinlan*, 70 N.J. 10, 41, 355 A.2d 647, 664, *cert. denied sub nom.*, 429 U.S. 922 (1976). The court stated:

The sad truth, however, is that [Karen] is grossly incompetent and we cannot discern her supposed choice based on the testimony of her previous conversations with friends. . . . Nevertheless we have concluded that Karen's right of privacy may be asserted on her behalf by her guardian under the peculiar circumstances here present.

Id.

26. *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 12, 426 N.E.2d 809, 816 (C.P. Summit Co. P. Div. 1980).

The limitations of *Leach I*, now apparent, demand attention. But first, any attempt to remedy the insufficiencies of *Leach I* requires consideration of the *other* Ohio life support case.

C. Leach II: *Informed Consent and the Right to Refuse*

In a separate and subsequent action filed on behalf of Mrs. Leach's estate, the Court of Appeals of Summit County addressed Mrs. Leach's right to refuse life support treatment prior to life support application.²⁷ The issue was not whether and under what circumstances a patient may secure the removal of life supports, but whether or not a cause of action for wrongful application of life supports existed.²⁸ The court decided a wrongful application cause of action was judicially cognizable and remanded the case for further fact finding.²⁹

Reversing the trial court's grant of defendants' 12(B)(6)³⁰ motion to dismiss, the court applied the common law doctrines of battery and informed consent rather than the constitutional analysis of *Leach I*.³¹ Informed consent doctrine requires a physician to disclose to a patient all material facts pertaining to that patient's condition, including likely risks involved in treatment.³² Treatment without disclosure and without subsequent patient consent gives rise to liability for battery. The representative of Mrs. Leach's estate alleged that physicians not only ordered the application of life supports without the consent of Mrs. Leach or her family, but in direct contravention of Mrs. Leach's express desires.³³ Recognizing that a medical emergency may give rise to implied consent to treatment, the court nevertheless concluded that "where the parties contract expressly with regard to a particular procedure, an implied agreement *cannot* thereafter arise when the express agreement directly controverts the inclusion of any such implication."³⁴ In short, if Mrs. Leach expressly refused life support application, subsequent application—emergency or no emergency—would trigger physician liability for battery.

The court added one caveat: the patient's life support refusal "must satisfy the same standards of knowledge and understanding required for informed consent."³⁵ The patient must be made to understand the risks incident to life support removal. This cautionary standard appears to be employed to insure that patients who have expressed vague or casual desires to die peacefully will not be denied treatment by liability-fearing physicians.

Finally, the court affirmed the vitality of *Leach I*, holding that once introduced

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

28. *Id.* at 395, 469 N.E.2d at 1051.

29. *Id.* at 393, 398, 469 N.E.2d at 1047, 1055.

30. Ohio R. Civ. P. 12(B)(6).

31. Estate of Leach v. Shapiro, 13 Ohio App. 3d 393, 395, 469 N.E.2d 1047, 1051 (1984).

32. See, e.g., Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093, *reh'g denied*, 187 Kan. 186, 354 P.2d 670 (1960).

33. Estate of Leach v. Shapiro, 13 Ohio App. 3d 393, 396, 469 N.E.2d 1047, 1053 (1984).

34. *Id.* (emphasis added).

35. *Id.* at 397, 469 N.E.2d at 1053.

as part of an authorized treatment plan, life supports may only be withdrawn from a comatose patient via court order.³⁶

D. Leach II: *Not Enough to Fill the Void*

1. *Strengthening Self-Determination*

Leach II, recognizing the doctrine of informed consent as the common law foundation supporting a patient's right to refuse the application of life support systems,³⁷ strengthened the terminal patient's ability to control the quantity and quality of medical treatment he or she receives. However, this doctrine, seemingly designed to protect a patient's right to self-determination, often fails to do just that. In *John F. Kennedy Memorial Hospital v. Heston*,³⁸ in which a patient's mother refused to consent to blood transfusions thereby threatening the life of her child, the New Jersey Supreme Court upheld the right of the hospital to administer the transfusions, reasoning that medical discretion may supersede a patient's interests:

[W]hen the hospital and staff are thus involuntary hosts and their interests are pitted against the belief of the patient, we think it reasonable to resolve the problem by permitting the hospital and its staff to pursue their functions according to their professional standards. The solution sides with life, the conservation of which is, we think, a matter of state interest.³⁹

Leach II implicitly rejects a balancing of physician and patient interests where the patient has expressly refused treatment. The court clearly denounces the impermissible use of implied consent to defeat patient intent: "Carried to its extreme . . . the doctrine of implied consent could effectively nullify those privacy rights recognized in *In re Quinlan* . . . and *Leach I* . . . since a physician could circumvent the express wishes of a terminal patient by waiting to act until the patient was comatose and critical."⁴⁰ In short, *Leach II* reinforces the use of informed consent as a method of securing the terminally ill patient's right to self-determination. Indeed, "Anglo-American law starts with the premise of *thorough-going self-determination*. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment."⁴¹

2. *An Insufficient Solution*

Though *Leach II* recognizes the right of a terminally ill patient to refuse life supports and also supplies a remedy in tort for denial of that right, its inherent

36. *Id.* at 396, 469 N.E.2d at 1053.

37. *Id.* at 395, 469 N.E.2d at 1051. See also notes 27-35 and accompanying text.

38. 58 N.J. 576, 279 A.2d 670 (1971).

39. *Id.* at 583, 279 A.2d at 673. See also Freamon, *Death with Dignity Laws: A Plea for Uniform Legislation*, 5 SETON HALL LEGIS. J. 105, 111 (1982).

40. Estate of Leach v. Shapiro, 13 Ohio App. 3d 393, 396-97, 469 N.E.2d 1047, 1053 (1984).

41. Natanson v. Kline, 186 Kan. 393, 406-07, 350 P.2d 1093, 1104 (1960) (emphasis added). See also Congrove v. Holmes, 37 Ohio Misc. 95, 308 N.E.2d 765 (1973). In *Congrove*, an Ohio court approvingly paraphrases the above cited language from *Natanson*, commenting that "the law does not permit [a physician] to substitute his own judgment for that of the patient." *Id.* at 103, 308 N.E.2d at 770.

limitations, like those of its predecessor, render it incapable of filling the gap in Ohio life support law.

Procedurally, *Leach II* reached the Court of Appeals after failing to survive defendants' 12(B)(6) motion to dismiss.⁴² Consequently, no trial transcript and no evidence were available for appellate review. The plaintiffs' complaint and defendants' response thereto provided a sparse record from which to make law of such import. This procedural limitation mutes *Leach II*'s ability to speak to the details of the life support application question.

Leach II holds that a terminally ill patient may recover in tort from a physician who attaches the patient to life supports contrary to that patient's express wishes.⁴³ But what constitutes express wishes and who may convey them? *Leach II*'s procedural posture gave the court no record from which to glean answers to these and other questions. Even more disconcerting, the court comments that it wishes to protect both doctor and patient from "statements not made in contemplation of the specific circumstances and the specific medical treatment required."⁴⁴ Will the court give no weight to a patient's desire to refuse life supports if not conveyed in apprehension of imminent, irreversible coma? Or is this cited material mere advisory dictum? The opinion provides little guidance.

Early in the text, commenting on the general law of informed consent, the court noted that "[w]here the patient is not competent to consent, an authorized person may consent in the patient's behalf."⁴⁵ Who is an authorized person—a guardian, spouse, immediate or extended family member? More importantly, may this authorized person *refuse* treatment as well as give consent? If the authorized person may refuse, must he or she base the decision on the patient's express wishes? What may the authorized person decide if the patient's express wishes are not apparent? The opinion offers no answers to these questions. Physicians, patients, and their lawyers may only speculate.

Substantively, *Leach II* raises other concerns not so easily explained. First, *Leach II* acknowledges the constitutionally based right to privacy approach of *Leach I*,⁴⁶ but shuns this approach in analyzing Mrs. Leach's right to refuse life support application. Are we to assume that the distinction between life support removal and life support refusal is of constitutional consequence? Regardless, if the trial and appellate courts of Summit County cannot agree on the applicable source of law, the prospect of state wide uniformity (absent state supreme court or legislative action) appears slim and the prospect of uncertainty appears likely.

Second, the court in *Leach II* saw fit to affirm in dicta the result of *Leach I*: "We join these courts that require judicial authority for the termination of life-prolonging treatment of an incompetent patient."⁴⁷ Interestingly, the issue of life support termination or removal was not properly before the court and was in fact quite moot—

42. Estate of Leach v. Shapiro, 13 Ohio App. 3d 393, 395, 469 N.E.2d 1047, 1051 (1984).

43. *Id.* at 397, 469 N.E.2d at 1054.

44. *Id.* at 397, 469 N.E.2d at 1053.

45. *Id.* at 395, 469 N.E.2d at 1052.

46. *Id.* at 396, 469 N.E.2d at 1053.

47. *Id.*

Mrs. Leach had died three years earlier.⁴⁸ Why the court affirmed the *Leach I* result (without even citing *Leach I*) is far from clear. The court never said a competent patient can secure life support removal with or without judicial intervention, though either outcome would seem harmonious with the court's analysis of the refusal question. If a competent patient can refuse treatment, surely he or she can refuse continued treatment. Though the logic may be appealing, it is the author's, not the court's. Because the court only mentions the removal question in dicta, the removal rights of the competent (noncomatose) patient remain uncertain.

E. Awaiting a Solution

In sum, *Leach I* and *Leach II* stand for two propositions. First, the right exists for the terminally ill, comatose patient to secure removal of life supports. Second, the terminally ill, competent patient may refuse life support application and enforce that refusal with a cause of action in tort. But the scope of these rights, the methods in which they may be exercised, and their applicability to similarly situated patients remain in doubt. The common law, whether gleaned from the doctrine of informed consent or the constitutional right to privacy, may provide solutions to specific life support problems before a court.⁴⁹ But will case by case decisions eradicate physician liability in effectuating patient intent? Clearly not. The limitations of the two Ohio opinions are glaring, but not for want of sound legal reasoning or judicial decision making. Lower courts simply cannot provide uniform rules, and no court can do more than resolve a dispute among the litigants before it. Courts cannot magically produce litigants to present the particular issues that must be addressed.

Recognition of the judiciary's inability to solve the life support problem is not enough. The explosive growth of sophisticated medical techniques guarantees that large numbers of patients and physicians will face daily life support decisions with only insufficient legal guidelines defining their respective rights and responsibilities. Because our "capacity to prolong life exceeds our capacity to cure,"⁵⁰ the pool of implicated parties will only grow larger. The law must move swiftly and efficiently to keep pace. The court in *Leach II* noted that it must decide life support cases "[u]ntil such time as the legislature provides some more efficient means of protecting the rights of patients in Mrs. Leach's condition"⁵¹ That time has surely come.

According to Bernard Freamon, Assistant Professor of Law at Seton Hall Law Center and a proponent of uniform life support laws, "legislation is the only concrete approach available to our legal system in dealing with problems associated with the terminally ill."⁵² The legislature, with its ability to deliberate and seek input from all segments of the medical and legal communities, is eminently better suited than a court to address life support issues. Though a court is bound to resolve disputes only among

48. Mrs. Leach died January 6, 1981. *Id.* at 394, 469 N.E.2d at 1051.

49. See Freamon, *supra* note 39, at 114.

50. Note, *The Kansas Natural Death Act*, 19 WASHBURN L.J. 519 (1979-1980).

51. *Estate of Leach v. Shapiro*, 13 Ohio App. 3d 393, 396, 469 N.E.2d 1047, 1052-53 (1984).

52. Freamon, *supra* note 39, at 119.

present litigants, the legislature may conduct an inquiry broad enough to formulate a workable framework for all potentially implicated parties.

III. A LEGISLATIVE SOLUTION

To date, the legislatures of twenty-two states and the District of Columbia have enacted "living will" legislation⁵³ detailing the rights and responsibilities of patients and physicians facing the life support decision. Typically, each statute authorizes competent patients to execute a directive, or living will, which requires their attending physicians to conduct treatment in accord with their desires in the event of terminal illness.⁵⁴ All of the states, save Arkansas,⁵⁵ require a diagnosis of terminal illness prior to life support withdrawal. As Freamon notes, "[t]he directive, put simply, is nothing more than a written memorialization of the patient's instructions to his doctor."⁵⁶

Living will statutes aid the terminally ill patient and his or her physician in three ways. First, a living will defines the scope of the patient's informed consent. Adequately drafted, a living will conveys patient intent, providing "definitive evidence of a patient's prior wishes."⁵⁷ Quite simply, a living will tells a doctor that the patient consents to procedure X, but refuses treatment Y. Second, the nature and extent of a patient's consent made apparent, the directive diminishes the need for costly, cumbersome litigation.⁵⁸ Third, all living will statutes grant physicians criminal and civil immunity for acting in accord with the will's provisions.⁵⁹ Eliminating the risk of liability encourages physicians to act in a situation where the fear of a civil suit or criminal prosecution might otherwise inhibit their actions. The immunity provisions aid the physician in effectuating patient intent.

Beyond these three common characteristics, living will statutes vary—both in overall scope and insignificant detail. At the risk of overgeneralization, this Note will address the advantages and disadvantages of three legislative approaches, seeking an

53. See ALA. CODE §§ 22-8A-1 to -10 (1984); ARK. STAT. ANN. §§ 82-3801 to -3804 (Supp. 1985); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1985); DEL. CODE ANN. tit. 16, §§ 2501-2508 (1983); D.C. CODE ANN. §§ 6-2421 to 2430 (Supp. 1985); FLA. STAT. ANN. § 765.01-.15 (West Supp. 1985); GA. CODE §§ 31-32-1 to -12 (1985); IDAHO CODE §§ 39-4501 to -4508 (1985); ILL. ANN. STAT. ch. 110 1/2, §§ 701-710 (Smith-Hurd Supp. 1985); KAN. STAT. ANN. §§ 65-28-101 to -109 (1980); LA. REV. STAT. ANN. §§ 40:1299.58.1-10 (West Supp. 1985); MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1984); NEV. REV. STAT. §§ 449.540-.690 (1983); N.M. STAT. ANN. §§ 24-7-1 to -10 (1978 & Supp. 1985); N.C. GEN. STAT. §§ 90-320 to -322 (Supp. 1983); OR. REV. STAT. §§ 97.050-.090 (1983); TEX. REV. CIV. STAT. ANN. art. 4590h (Vernon Supp. 1985); VT. STAT. ANN. tit. 18, §§ 5251-5262 (Supp. 1985); VA. CODE § 54-325.8:1-13 (Supp. 1985); WASH. REV. CODE ANN. § 70.122.010-.905 (Supp. 1985); W. VA. CODE § 16-30-1 to -10 (1985); WIS. STAT. ANN. §§ 154.01-.15 (West Supp. 1985); WYO. STAT. §§ 33-26-144 to -152 (Supp. 1985).

54. Freamon, *supra* note 39, at 123. See, e.g., OR. REV. STAT. §§ 97.050-.090 (1983); WASH. REV. CODE ANN. §§ 70.122.010-.905 (Supp. 1984).

55. See ARK. STAT. ANN. §§ 82-3801 to -3804 (Supp. 1985).

56. Freamon, *supra* note 39, at 124.

57. *Id.*

58. *Id.*

59. Freamon, *supra* note 39, at 133. See, e.g., ILL. ANN. STAT. ch. 110 1/2, § 707 (Smith-Hurd Supp. 1985): No physician, licensed health care professional, medical care facility or employee thereof who in good faith and pursuant to reasonable medical standards causes or participates in the withholding or withdrawing of life-sustaining procedures from a qualified patient pursuant to a declaration which purports to have been made in accordance with this Act shall as a result thereof, be subject to criminal or civil liability, or be found to have committed an act of unprofessional conduct.

efficient statutory scheme with which to supplement, if not supplant, current Ohio law.⁶⁰

A. *The California Approach*

Three states, California, Idaho, and Texas, enforce a living will if and only if the patient executed the document subsequent to a diagnosis of terminal illness.⁶¹ While the Idaho statute does not address the binding effect of a living will executed prior to a terminal diagnosis, the California and Texas acts, in identical language, permit the physician to “give weight to the directive as evidence of the patient’s directions,” but absolve the physician of any liability if he or she fails to comply.⁶² In other words, a living will executed in advance of a terminal diagnosis is merely advisory. Though the California approach takes significant strides beyond the common law to insure that physicians will comply with their patients’ treatment requests, it falls short in significant respects.

The California approach, though inventive and trail-blazing at its enactment,⁶³ fails to adequately address the needs of two patient groups: patients who execute a living will prior to a terminal diagnosis and patients who do not execute a living will at all. Group one patients—those holding prediagnosis wills—may reexecute wills, securing the effectuation of their intent.⁶⁴ However, should group one patients lapse into coma prior to reexecution, their express wishes, as memorialized in the prediagnosis will, become merely advisory. The postdiagnosis requirement, designed to promote serious reflection and “finality of decision,”⁶⁵ may instead thwart patient intent, prolonging pain and expense.

Admittedly, the California approach provides a procedure by which patients who can comply with its postdiagnosis requirement may secure the effectuation of their intent. However, the advisory nature of a prediagnosis will and the approach’s generally limited scope prevent it from filling the void in Ohio common law.

Section 7191(c) of the California act, if adopted in Ohio, would eliminate the *Leach II* wrongful application remedy for group one patients. Section 7191(c) absolves physicians from civil or criminal liability for failing to effectuate a prediagnosis will,⁶⁶ while *Leach II* provides a civil remedy for application or retention contrary to the patient’s express wishes.⁶⁷ If *Leach II* took a tentative step toward effectuating a patient’s express wishes, adopting the California approach in Ohio

60. The legislative approaches are labeled by state name for ease of recall and reference. The states chosen are merely illustrative of a particular legislative approach. The acts of more than one state may be used to demonstrate the characteristics of a particular approach.

61. CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1985); IDAHO CODE §§ 39-4503 to -4504 (1985); TEX. REV. CIV. STAT. ANN. art. 4590h, §§ 2(5), 7(b) (Vernon Supp. 1985). See also Freamon, *supra* note 39, at 125.

62. See CAL. HEALTH & SAFETY CODE § 7191(c) (West Supp. 1985); TEX. REV. CIV. STAT. ANN. art. 4590h, § 7(c) (Vernon Supp. 1985).

63. The California act, the first of the living will statutes, passed the state legislature September 30, 1976 and became effective January 1, 1977. 1976 Cal. Stat. 6478.

64. CAL. HEALTH & SAFETY CODE § 7191(b) (West Supp. 1985).

65. Freamon, *supra* note 39, at 125.

66. CAL. HEALTH & SAFETY CODE § 7191(c) (West Supp. 1985).

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

would signal retreat, permitting physicians under a shield of immunity to ignore a patient's intent expressed prior to diagnosis of terminal illness.

Similarly, the California approach constitutes no improvement over Ohio law with respect to group two patients—those who have not executed a living will at all. The enactment of a statute based on section 7193 of the California act would preserve an Ohio patient's common law rights under *Leach I* and *II*. Section 7193 provides in part: "Nothing in this chapter shall impair or supercede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures" ⁶⁸ However, a provision similar to section 16-30-9 of the West Virginia Natural Death Act ⁶⁹ might better preserve these limited rights. The West Virginia provision mirrors the quoted California section but adds: "This article creates no presumption concerning the intention of an individual who has not executed . . . [a living will]." ⁷⁰

But is an act which offers little improvement over *Leach I* and *II* desirable? The California approach would leave Ohio's Karen Quinlans and Edna Marie Leaches with nothing more than their cumbersome common law rights, replete with inadequacies. Must the legislature leave the group two patient, the patient who has not executed a living will, with only his limited *Leach* rights? Surely not. Alternatives exist that demand consideration.

B. The North Carolina Approach

The General Assembly of North Carolina moved to fill the perceived inadequacies of the California approach by enacting the North Carolina Natural Death Act in June of 1977. ⁷¹ The North Carolina approach neither impairs the effectiveness of a living will executed prior to a terminal diagnosis nor ignores the right of the patient who never executed a living will. States adhering to the North Carolina approach include Florida, Louisiana, New Mexico, Oregon, and Virginia. ⁷²

The North Carolina approach typically provides that "[a]ny competent adult may, at any time" ⁷³ execute a living will; date of execution in no way diminishes the effectiveness of the document. ⁷⁴ Supporters of the California approach suggest this provision allows for casual decision making at a time remote from the hard facts of terminal illness. They worry that "the hale and hearty executive of forty who files a living will in a burst of exuberance may have second thoughts on the matter when actually confronting the situation." ⁷⁵ Proponents of the North Carolina approach

68. CAL. HEALTH & SAFETY CODE § 7193 (West Supp. 1985).

69. W. VA. CODE § 16-30-9(a), (b) (1985).

70. *Id.*

71. N.C. GEN. STAT. §§ 90-320 to -322 (Supp. 1983).

72. See FLA. STAT. ANN. §§ 765.01-15 (West Supp. 1985); LA. REV. STAT. ANN. §§ 40:1299.58.1-10 (West Supp. 1985); N.M. STAT. ANN. §§ 24-7-1 to -11 (1978 & Supp. 1985); OR. REV. STAT. §§ 97.050-.090 (Supp. 1983); VA. CODE § 54-325.8:3, 6 (Supp. 1985).

73. VA. CODE § 54-325.8:3 (Supp. 1984) (emphasis added).

74. *Contra* CAL. HEALTH & SAFETY CODE § 7191(c) (West Supp. 1985).

75. Comment, *North Carolina's Natural Death Act: Confronting Death with Dignity*, 14 WAKE FOREST L. REV. 771, 787 (1978).

respond that the patient may easily revoke his or her living will, orally or otherwise.⁷⁶ Moreover, is a decision made in anticipation of death necessarily a *better* estimation of a patient's true intent? A living will executed or reexecuted only after a terminal diagnosis, as the California approach prefers, may suffer from the taint of the terminal patient's death wish. According to Luis Kutner, prior Chairman of the World Habeas Corpus Committee of the Center for World Peace Through Law, "[t]he study of psychology and psychoanalysis has indicated that all men have a suppressed urge for death, the death wish or *thanos*, which may emerge when an individual is seriously ill."⁷⁷

If the question is close, why impair the rights of the patient who chooses to memorialize his solemn decision prior to a terminal diagnosis? No one is forced to execute a living will. Our hale and hearty executive may just as easily be a thoughtful man of conscience who cherishes his right to self-determination. On balance, a document that effectuates express written intent, without regard to date of execution, seems preferable. Twenty of the twenty-three jurisdictions enacting living will statutes agree.⁷⁸

Though the North Carolina approach shares the positive attribute of prediagnosis effectiveness with the majority of living will statutes, its hallmark lies in its treatment of the comatose patient who has not executed a living will—a patient the California approach ignores. The North Carolina approach provides a mechanism by which the comatose patient who has not executed a living will may secure removal or exercise refusal of life supports despite his or her present incompetency.⁷⁹ The mechanism utilizes substituted judgement, allowing a patient's family members or legal guardian to effectuate the patient's intent.⁸⁰ Life supports may be withheld or withdrawn from a terminally ill, comatose patient upon an agreement between his or her attending physician and

any of the following individuals, in the following order of priority if no individual in a prior class is reasonably available, willing and competent to act:

1. The judicially appointed guardian or committee of the person of the patient if one has been appointed. This paragraph shall not be construed to require such appointment in order that a treatment decision can be made under this section;
2. The person or persons designated by the patient in writing to make the treatment decision for him should he be diagnosed as suffering from a terminal condition; or
3. The patient's spouse; or

76. See, e.g., N.C. GEN. STAT. § 90-321(e) (1981); VA. CODE § 54-325.8:5 (Supp. 1985).

77. Kutner, *Due Process of Euthanasia: The Living Will, A Proposal*, 44 IND. L.J. 539, 545 (1969).

78. See ALA. CODE § 22-8A-4 (1984); ARK. STAT. ANN. § 82-3802 (Supp. 1985); DEL. CODE ANN. tit. 16, § 2502 (1983); D.C. CODE ANN. § 6-2422 (Supp. 1985); FLA. STAT. ANN. § 765.04 (West Supp. 1985); GA. CODE § 31-32-3 (1985); ILL. ANN. STAT. ch. 110 1/2, § 703 (Smith-Hurd Supp. 1985); KAN. STAT. ANN. § 65-28-103 (1980); LA. REV. STAT. ANN. § 40:1299.58.3 (West Supp. 1985); MISS. CODE ANN. §§ 41-41-105, -107 (Supp. 1984); NEV. REV. STAT. §§ 449.600, .610 (1983); N.M. STAT. ANN. § 24-7-3 (Supp. 1985); N.C. GEN. STAT. § 90-321 (Supp. 1983); OR. REV. STAT. § 97.055 (1983); VT. STAT. ANN. tit. 18, § 5253 (Supp. 1985); VA. CODE § 54-325.8:3 (Supp. 1985); WASH. REV. CODE ANN. § 70.122.030 (Supp. 1985); W. VA. CODE § 16-30-3 (1985); WIS. STAT. ANN. § 154.03 (West Supp. 1985); WYO. STAT. § 33-26-145 (Supp. 1985).

79. See, e.g., N.C. GEN. STAT. § 90-322 (Supp. 1983); VA. CODE § 54-325.8:6 (Supp. 1985).

80. See *id.*

4. An adult child of the patient or, if the patient has more than one adult child, by a majority of the children who are reasonably available for consultation; or
5. The parents of the patient; or
6. The nearest living relative of the patient.⁸¹

Should a physician refuse to comply with the decision of one of those persons enumerated in subsections one through six, section 54-325.8:7 of the Virginia Natural Death Act instructs that the physician is to make reasonable efforts to transfer the patient to another physician.⁸² Notably, the provision does not *require* refusal or removal, but leaves the decision with those best suited to make it—the patient's legal representative and family.

The North Carolina approach addresses the plight of Ohio's Karen Quinlans and Edna Marie Leaches, unequivocally constituting an improvement over *Leach I* and *II*. The North Carolina approach cautiously and clearly delineates who, under what circumstances, may give force to an incompetent's informed consent and who may exercise the incompetent's right of privacy. Further, this statutory scheme provides a framework applicable to all similarly situated patients. The rules and law will not vary, as they may under *Leach I* and *II*, with the court from which a plaintiff seeks relief.⁸³ In fact, the North Carolina approach, eliminating physician liability for compliance with the act,⁸⁴ obviates the need for litigation. Free of liability and equipped with clear statutory guidelines, physicians should be generally less reluctant to accord life support treatment with patient intent.⁸⁵ Finally, eliminating the need for litigation decreases both the time that undesired life supports maintain a comatose patient and the emotional and fiscal strain imposed upon his or her family.

As a matter of illustration, consider the *Leach I* facts with only one variation—that Mrs. Leach becomes ill in a state adopting the North Carolina approach. Mrs. Leach's husband, as both her spouse and her guardian, could, pursuant to the Natural Death Act, direct the discontinuance of life supports. Her physician, assured of civil and criminal immunity, may simply comply or transfer Mrs. Leach to a physician who will. In sum, the statute, via substituted judgement, quickly and efficiently effectuates Mrs. Leach's intent, obviates the need for a subsequent suit for wrongful application, and eliminates her physician's liability.

C. *The Uniform Approach*

The National Conference of Commissioners on Uniform State Laws (NCCUSL), authors of the Uniform Anatomical Gift Act⁸⁶ and the Uniform Determination of Death Act,⁸⁷ have proffered a tentative draft of the Rights of the Terminally Ill Act (RTIA),⁸⁸ a uniform living will statute. The statute parallels the North Carolina

81. VA. CODE § 54-325.8:6 (Supp. 1985).

82. *Id.* § 54-325.8:7.

83. See *supra* text pp. 1021, 1025.

84. See VA. CODE § 54-325.8:8 (Supp. 1985).

85. See Comment, *The Virginia Natural Death Act—A Critical Analysis*, 17 U. RICH. L. REV. 863, 871 (1982-83).

86. §§ 1-11, 8A U.L.A. 30-67 (1983).

87. §§ 1-3, 12 U.L.A. 271-72 (West Supp. 1985).

88. THE RIGHTS OF THE TERMINALLY ILL ACT §§ 1-12 (Tent. Draft 1984).

approach in certain important respects. RTIA cautiously outlines the rights of the terminally ill patient to direct the withholding or withdrawal of life supports via a simple written directive⁸⁹ and provides physicians and other health care providers immunity for following their patients' treatment decisions.⁹⁰ Further, RTIA provides that an individual may execute a living will "at any time."⁹¹ No postdiagnosis requirement is imposed. But here the significant parallels stop.

RTIA in its current form fails to provide for the rights of comatose patients who have not executed living wills, leaving the needs of these patients to state common law.⁹² Though uniformity may answer questions of reciprocity and solve the problems implicated by a highly mobile population, a uniform act should glean the best provisions from the several state acts.⁹³ To meet the needs of Ohio's terminally ill, RTIA must adopt a North Carolina provision with respect to the comatose patient who has no living will. To ignore these patients' needs is to retain the inadequacies of the *Leach* decisions.

D. *Toward an Ohio Act*

If the insufficiencies of Ohio common law are to be remedied, the Ohio General Assembly must act. Living will legislation is not new to Ohio's state legislators. Considered in both the 114th and 115th General Assemblies, two living will proposals failed to become Ohio law.⁹⁴ According to a sponsor of both bills, State Representative Robert Nettle, two major factors caused the bills to languish in committee: 1) unacceptable amendments tactically imposed by opposition forces in the 114th General Assembly; and 2) election year fears of young legislators hoping to avoid the potential wrath of the bill's detractors in the 115th General Assembly.⁹⁵ The 116th General Assembly is currently reviewing House Bill No. 220 (H.B. 220),⁹⁶ another proposed living will act. Consequently, the questions of whether and what kind of living will legislation Ohio needs become all the more salient.

A legislative package worthy of enactment should address and correct the *Leach* inadequacies, securing the terminal patient's right to self-determination. A synthesis of NCCUSL's RTIA and H.B. 220 provides this package. RTIA offers the framework: a carefully drafted bill which gives effect to a patient's express wishes whether memorialized before or after a terminal diagnosis.⁹⁷ RTIA adds the attraction of potential uniformity, helping to insure that the situs of illness or injury will not impair

89. *Id.* at § 2.

90. *Id.* at § 7.

91. *Id.* at § 2(a).

92. *See id.* at § 9(d).

93. *See* Freamon, *supra* note 39, at 140.

94. Ohio H.B. 137, 114th Gen. Assembly, Reg. Sess. (1981-82); Ohio H.B. 331, 115th Gen. Assembly, Reg. Sess. (1983-84).

95. Telephone interview (March 1, 1985).

96. Ohio H.B. 220, 116th Gen. Assembly, Reg. Sess. (1985-86). H.B. 220 passed the Ohio House of Representatives on June 26, 1985 and is presently pending before the Ohio Senate.

97. THE RIGHTS OF THE TERMINALLY ILL ACT § 2 (Tent. Draft 1984). *CONTRA CAL. HEALTH & SAFETY CODE* § 7191(c) (West Supp. 1985).

a patient's rights. RTIA, however, does not include a North Carolina provision that details the rights of the comatose patient who has not executed a living will.⁹⁸

This gap may be filled with section 2108.38 of Ohio's own H.B. 220.⁹⁹ Ohio Bill section 2108.38 substantially parallels the previously discussed North Carolina provisions, permitting a patient's spouse, guardian, or immediate family to effectuate that patient's intent and protect a physician who acts at their direction from any liability.¹⁰⁰ However, H.B. 220 improves on previous North Carolina provisions by adding section 2108.38(B):

If the spouse, guardian, parents, adult children, or adult siblings of an adult in the condition described in division (A) of this section disagree over the use, withholding, or discontinuation of medical measures, any of them may apply to the probate court . . . for an order on the use, withholding or discontinuation of medical measures.¹⁰¹

This North Carolina provision takes away from the courts that which is more efficiently decided elsewhere—what to do if the comatose patient's guardian, spouse, and family all agree as to the patient's desires. The provision leaves to the court that which courts are best suited to decide—disputes among interested parties.¹⁰²

In sum, a revised RTIA, amended to include H.B. 220's section 2103.38, significantly improves upon Ohio common law. Patients may expressly define the scope of their informed consent via a written directive. Patients who do not execute a directive may nevertheless obtain relief from undesired treatment. Physicians may comply with their patients' desires without fear of liability. Importantly, Ohio law under a synthesis of RTIA and H.B. 220 would be poised to handle the increasing number of patients facing the life support decision. With the requirement of cumbersome probate court litigation removed, physicians could tailor treatment to their patients' informed instructions without clogging court dockets or paying legal retainers.

IV. CONCLUSION

Though no panacea, legislation clearly offers the surest means to fill the insufficiencies of Ohio's life support law. Absent legislative action, Ohio's terminal patients and their physicians can only hope the common law keeps pace with the burgeoning advances in sophisticated medical technology. This is an unlikely prospect. If the General Assembly remains silent, developing technology will exponentially increase the number of patients and physicians forced to make life support decisions in legal limbo, unsure of their rights and blind to their duties.

98. See *supra* text accompanying note 92.

99. Ohio H.B. 220, 116th Gen. Assembly, Reg. Sess. (1985-86).

100. *Id.* at § 2108.38(A).

101. *Id.* at § 2108.38(B).

102. The Washington Supreme Court supplemented that state's living will act, holding that in most instances no judicial intervention is required to remove life supports from an incompetent. As in H.B. 220, litigation only becomes necessary when disagreement arises among enumerated parties (for example, legal guardian, treating physicians, prognosis committee). See *In re Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

If the General Assembly must act, it must do so prudently and comprehensively. Poorly drafted stopgap measures will surely raise more questions than they answer. An Ohio act must address all implicated patient groups: competent, comatose, those who have executed a living will, and those who have not. The act must glean the best provisions from the already proposed legislative responses. Finally, it must enable physicians to effectuate patient intent without fear of liability. An amended RTIA meets these requirements.

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