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The Current State of Advance Directive Law in Ohio: More Protective of Provider Liability than Patients Rights

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THE CURRENT STATE OF ADVANCE DIRECTIVE LAW IN
OHIO: MORE PROTECTIVE OF PROVIDER LIABILITY THAN
PATIENT RIGHTS

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I. INTRODUCTION

Edna Marie Leach was a healthy, energetic, seventy year-old woman who lived with her husband, Gifford, in a modest home near Akron, Ohio.¹ Edna and Gifford had two grown children who no longer lived with their parents. Edna maintained close relationships with her children and her siblings, and she had many friends in the community.²

One day, Edna began suffering from lower back pain, followed by muscle weakness in her lower body. She began walking hunched-over and finally visited a physician to seek treatment for her ailments. Edna was diagnosed with a progressive, disabling disease of the nervous system, named amyotrophic lateral sclerosis.³ Edna's physician informed her that this disease was terminal and would eventually physically incapacitate her. Edna's physician estimated that she would die from the disease within three to five years.

Following her diagnosis, Edna informed family members and friends that she did not wish to be kept alive by artificial means, such as machines. She stated that the idea of being kept alive by machines terrified her. Edna made similar statements to her husband, sister, two cousins, and various friends. One month after her diagnosis, Edna's health rapidly deteriorated. Shortly after being admitted to a local hospital for respiratory distress, Edna suffered a cardiac arrest. Cardiopulmonary resuscitation⁴ was successfully administered, and a respirator was surgically inserted

¹See generally *Leach v. Akron Gen. Med. Ctr.*, (*Leach I*), 426 N.E.2d 809 (Summit County Ct. Com. Pl.1980). The facts regarding Edna Leach as contained within the introduction of this note can be found in the court's opinion. See generally *id.*

²*Id.*

³Amyotrophic lateral sclerosis is defined as "a rare fatal progressive degenerative disease that affects pyramidal motor neurons, usually begins in the middle age, and is characterized especially by increasing and spreading muscular weakness—abbreviation *ALS*; it is also called *Lou Gehrig's disease*." Dictionaryreference, <http://www.dictionaryreference.com/search?q=amyotrophic%20lateral%20sclerosis>.

⁴Cardiopulmonary resuscitation is defined as "a procedure designed to restore normal breathing after cardiac arrest that includes the clearance of air passages to the lungs, mouth-to-mouth method of artificial respiration, and heart massage by the exertion of pressure on the chest." Dictionaryreference, <http://www.dictionaryreference.com/search?r=2&q=cardiopulmonary%20resuscitation>.

into her trachea to facilitate breathing. A nasogastric tube was also inserted into her stomach to facilitate the administration of nutrition.

Edna's physicians diagnosed her as being in a permanent, chronic, vegetative state.⁵ Despite protests by Edna's husband and children of her intentions to not be kept alive in that state, Edna's physician informed her family that according to Ohio law, "life support could only be terminated by a court order."⁶ Five months later, after an evidentiary hearing that included the testimony of seventeen witnesses,⁷ a court order was issued directing the termination of Edna's life support.⁸ Three weeks after the order was issued, Edna's respirator was finally disconnected, and she subsequently died.⁹

Following Edna's death, her family sought to recover damages from the hospital for "pain, suffering, and mental anguish"¹⁰ on behalf of their mother and themselves.¹¹ Additionally, her family alleged that the hospital administered treatments without proper consent.¹² Prior to the Leach family's lawsuit in 1980, Ohio courts did not have Ohio statutory or case law to guide them in their decision regarding whether a terminally ill patient had the right to refuse future medical treatment.¹³ While the Leach family did not successfully recover damages at trial,

⁵OHIO REV. CODE ANN. § 2133.01 (U) (West 2006).
"Permanently unconscious state"

means a state of permanent unconsciousness in a declarant or other patient that, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by the declarant's or other patient's attending physician and one other physician who has examined the declarant or other patient, is characterized by both of the following: (1) Irreversible unawareness of one's being and environment [and] (2) Total loss of cerebral cortical functioning, resulting in the declarant or other patient having no capacity to experience pain or suffering.

Id.

⁶*Leach I*, 426 N.E.2d at 811. ("In Ohio, at this time, the court system provides the only mechanism which can protect the interest of the doctor, the hospital, the patient, the family and the state, which can objectively weigh the competing interests in an emotionally charged situation, and which can insulate the participants from civil and criminal liability.") See also *Estate of Leach v. Shapiro*, (*Leach II*), 469 N.E.2d 1047, 1052 (Ohio Ct. App. 1984).

⁷*Leach I*, 426 N.E.2d at 811.

⁸*Leach II*, 469 N.E.2d. at 1051.

⁹*Id.*

¹⁰*Id.* at 1055.

¹¹*Id.*

¹²*Id.* at 1051, 1055 (the plaintiffs "allege[d] that some of [the] treatments [she received] were experimental."). Although the Leach family was unsuccessful in its attempt to recover damages under the common law theory of informed consent through court proceedings, the defendant-hospital ultimately settled out of court for \$50,000. See Vicki Joiner Bowers, *Elder Law Symposium: Comment: Advance Directives: Peace of Mind or False Security?*, 26 STETSON L. REV. 677, 702 n.138 (1996).

¹³*Leach I*, 426 N.E.2d at 816.

the *Leach* court was the first Ohio court to proclaim that the right to privacy, as encompassed within the United States Constitution, protected the right of a terminally ill patient in a permanent, vegetative state, to refuse medical treatment.¹⁴

Because competent patients generally have the right to refuse medical treatment, a person has the option to express his or her wishes regarding future medical care in the form of a written document called an advance directive. In fact, many people plan for mental incapacity later in life by executing advance directives¹⁵ that would take effect if they were declared incompetent as a result of disease or injury.¹⁶ An advance directive sets out, in writing, a person's desires regarding medical treatment in the event that the person cannot orally do so as a result of a mentally debilitating disease or injury. It is a written declaration that a patient can use to accept or refuse future medical treatment.¹⁷ When properly executed, an advance directive can be relied on by healthcare providers as a legal declaration of the patient's wishes.

Edna Leach died almost twenty-five years ago.¹⁸ Since that time, Ohio has adopted the Modified Uniform Rights of the Terminally Ill Act¹⁹ which governs the use and execution of written advance directives as expressions of a patient's desire to consent to or refuse future medical treatment. However, the Act also includes a provision that grants both civil and criminal immunity to health care providers who do not comply with a person's written advance directive. Unfortunately, because of the grant of civil and criminal immunity encompassed within the adopted written advance directive statutes, Ohio law today does not afford any greater protection of a patient's right to refuse medical treatment at the end-of-life through the use of a written declaration than it did when Edna Leach's wishes, as orally conveyed by her family, were disregarded at the end of her own life. In 2006, Ohio citizens, when confronting their own end-of-life decisions and considering the use of written advance directives, cannot be certain that their families will be spared the grief that the Leach family endured while they watched their mother be kept alive against her wishes in 1980.

¹⁴*Id.*

¹⁵See generally Last Acts: Means to a Better End, A Report on Dying in America Today, 19 (2002), available at <http://www.rwjf.org/files/publications/other/meansbetterend.pdf>. ("Currently, 47 states and the District of Columbia have laws authorizing living wills."). See also David M. English & Alan Miesel, *Uniform Health-Care Decisions Act Gives New Guidance*, Est., at 355 (Dec. 1994).

¹⁶OHIO REV. CODE ANN. § 2133.02 (West 2006); § 2133.03 (A) (1). For a detailed discussion of "never-competent persons" and end-of-life decisions, see Norman L. Cantor, J.D., *The Bane of Surrogate Decision-Making Defining the Best Interests of Never-Competent Persons*, 26 J. LEGAL MED. 155 (2005).

¹⁷In this note, the term "advance directive" is used as a general phrase that encompasses written declarations of a patient's right to make decisions about the health care they wish to consent to or refuse concerning end-of-life decisions, including living wills.

¹⁸*Leach II*, 469 N.E.2d at 1051.

¹⁹1991 Ohio Legis. Bill 159, 166-76 (LexisNexis) (codified as OHIO REV. CODE ANN. § 2133.01-15 (2006)). For a detailed analysis of the Uniform Rights of the Terminally Ill Act and the Uniform Health Care Decisions Act as adopted in the fifty states, see generally Bretton J. Horttor, *A Survey of Living Will and Advanced Health Care Directives*, 74 N.D. L. REV. 233 (1998).

This article will argue that Ohio law does not adequately protect an individual's right to autonomy when exercised through the implementation of an advance directive. In Part II, this article will examine the growing need for advance directives and attribute this need to the evolution of medical treatments, such as CPR, and the fear health care providers have regarding the inaccuracy and unreliability of a patient's orally expressed wishes regarding medical treatment as communicated through a patient's family members and loved ones. Part III will examine the history of the right to autonomy in Ohio, with specific emphasis on the *Leach* case and the Modified Uniform Rights of the Terminally Ill Act. Part IV will show how Ohio courts have undermined patients' rights to refuse medical treatment through the use of a written advance directive by prohibiting recovery to patients whose written advance directives have been blatantly disregarded and thus, have sued health care providers under Ohio's only permissible causes of action of negligence, battery, and intentional infliction of emotional distress. Finally, Part V will propose a four-part resolution, comprised of: repealing civil and criminal immunity; codifying a patient's right to seek a remedy; recognition of a national advance directive form; and encouraging awareness of a national living will directory.

II. THE GROWING NEED FOR ADVANCE DIRECTIVES

Patients can communicate their wishes regarding future health care decisions to health care providers through the use of advance directives in the form of either living wills or durable powers of attorney for health care,²⁰ which take effect in the event that the patient is declared incompetent.²¹ While living wills expressly convey a patient's wishes to a health care provider in the event that the patient becomes permanently unconscious or terminally ill, durable powers of attorney for health care appoint an authorized person, such as a family member or loved one, to make

²⁰Financial and Health Care Planning for the Elderly in Ohio § 1-8, (Matthew Bender & Co., Inc. ed.) (2004).

The two legal documents available for advance direction of health care decisions are the durable power of attorney for health care ('DPAHC') or other form of proxy and the living will. The living will is an advance 'instruction directive' to be followed in terminal or unconscious conditions. It directly tells the health care provider the patient's wishes; that is, it is self-executing. A DPAHC is a 'proxy directive;' it names an agent to make health care decisions for the patient at any time when he is unable to do so, although it may also include instructions from the patient. It is broader in scope than the living will, not being limited to treatment decisions in terminal or unconscious conditions, unless otherwise specified.

Id. Durable powers of attorney are outside the scope of this note. For statutory authority governing the use and implementation of durable powers of attorney in Ohio, *see generally* OHIO REV. CODE ANN. § 1337.11-17 (West 2006).

²¹Patients who were once competent, but later are determined incompetent due to age, illness or disease, are the focus of this note. This note does not address the legal complications that arise with patients who have never been competent, such as persons born severely disabled. For an in-depth analysis of the issues presented with decision-making and profoundly disabled persons, *see* Norman L. Cantor, *The Relation Between Autonomy-Based Rights and Profoundly Mentally Disabled Persons*, 13 ANNALS HEALTH L. 37 (2004).

medical decisions on behalf of the patient once a physician determines that the patient has become incompetent.²²

In most states, an advance directive must comply with certain formalities in order to be legally executed, and hence, deemed reliable by health care providers. An advance directive is intended to be a reliable and accurate reflection of a person's desires regarding difficult medical treatment decisions. Without a written document that clearly expresses an incompetent patient's wishes regarding medical treatment, the only method health care providers have to ascertain the patient's desires are the second-hand accounts of family members or loved ones. Because of the inherent reliability problems with second-hand accounts of a person's desires regarding difficult and emotionally charged medical decisions, health care providers often fear legal liability may arise if it were later discovered that the second-hand accounts were in fact inaccurate reflections of the patient's wishes.²³ Thus, advance directives are extremely useful as direct and reliable expressions of a patient's wishes.

Because a patient must be legally competent in order to make a rational, informed choice regarding medical care, states may establish special procedural safeguards to protect incompetent patients from having treatment withheld that the patient, were she competent, would herself choose to consent.²⁴ Such safeguards may include, in the absence of a written declaration, the requirement of a court order, as in the case of Edna Leach. Other safeguards are manifested in the form of statutory guidelines governing the execution of advance directives, such as requiring that the patient clearly express her wishes while still competent.²⁵ These safeguards, however, may inadvertently obstruct a patient's right to refuse medical treatment by requiring authenticated legal documentation that may be impractical or even impossible to obtain on short notice.

As life-sustaining technology evolves in the health care setting, advance directives play an increasingly important role for incompetent patients. Patients' fear of the administration of futile life-sustaining medical treatment, including cardiopulmonary resuscitation, combined with the public's interest in protecting incompetent patients' lives, has made advance directives and living wills an indispensable component in planning for end-of-life medical care.

A. The Misuse and Fear of Futile Medical Treatments Have Increased the Need for Written Advance Directives

Life-sustaining medical treatment is frequently administered in health care settings, even when the patient has no hope of recovery. Advance directives can guide a health care provider in determining whether a particular course of treatment

²²See generally Ohio's Durable Power of Attorney for Healthcare statute at § 1337.11-17; see also *Leach II*, 469 N.E.2d at 1052.

²³*Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261, 268 (1990) (finding that Nancy Cruzan's statements "to her roommate regarding her desire to live or die under certain conditions were 'unreliable for the purpose of determining her [intent].'"

²⁴*Id.* at 280.

²⁵For a detailed analysis of the standard of proof required by some states regarding an incompetent patient's right to refuse medical treatment, see generally Martha McKinley Gray, *Treatment Decisions: Making Them and Having Them Made for You*, 1 J. PHARMACY & L. 39 (1992).

would be deemed lifesaving or life-extending by the patient who is subject to the treatment and would give patients more autonomy over deciding whether or not to receive treatment that may be futile. Additionally, advance directives would decrease the risk that life-sustaining medical treatment would be administered because of a family member's inability to "let go," even if such administration is not in the patient's best interest.

In the absence of a legally executed written declaration, health care providers will likely look to the patient's family members to decide on the course of treatment that the family members wish to pursue. However, family members may not necessarily pursue the course of treatment that the patient herself would have chosen. During the emotionally charged circumstances which often accompany decisions regarding life-sustaining medical treatment, family members may find it impossible to determine that their loved one should not receive certain life-sustaining treatment. Thus, even where a health care provider determines that a patient is not likely to recover from or survive independently of life-sustaining treatment, there is an increased risk that such treatment may be administered in cases where the treatment merely serves to prolong physical death.

As the health care setting has evolved over the past 100 years, more people today die in hospital or nursing care settings as opposed to in their own homes.²⁶ This reality presents a moral dilemma regarding death and dying that never before arose in the traditional in-home setting due to the availability of life-sustaining medical treatments in hospital settings. The common use of life support systems in health care settings has increased the need for patients to express their wishes regarding their desire to consent to or refuse the administration of life support measures by executing written advance directives long before they are needed.

It was not long ago that questions dealing with the point at which biological death occurred were not so complex.²⁷ Advancements in medical technology have enabled the indefinite functioning of vital body systems.²⁸ As articulated by the *Leach* court, "[s]ince, man, through his ingenuity, has created a new state of human existence, minimal human life sustained by man-made life supports, it must now devise and fashion rules and parameters for that existence."²⁹ Written advance directives allow a person to clearly and expressly "fashion rules and parameters" for their existence in the event that she becomes incompetent.

Because the primary function of hospital and nursing home settings is to prolong a patient's life, health care providers may be unable to distinguish between lifesaving and life-extending measures and may be further unable to facilitate a suitable and humane end of life medical care.³⁰ Consequently, many patients spend the last days

²⁶Ernie W.D. Young, *Ethical Issues at the End of Life*, 9 STAN. L. & POL'Y REV. 267 (1998) ("Ethical decision-making at the end of life has become more complicated as medical technology continues to be developed and deployed at an accelerating rate. The successes of medicine generate rising social expectations of the health care system. Americans are living longer than ever before. They are now dying in hospitals rather than at home.").

²⁷*Leach I*, 426 N.E.2d at 812.

²⁸*Id.*

²⁹*Id.*

³⁰See Young, *supra* note 26, at 268.

of life suffering from the pain and discomfort that attends the administration of life-sustaining medical treatment, without any hope of regaining cognitive abilities.³¹

As life-sustaining medical technology has enabled the sustenance of a patient's biological life indefinitely, health care providers must determine which medical treatment options will serve only to prolong a patient's biological death.³² When determining the type of medical treatment to be administered at the end of life, health care providers may examine the "futility"³³ of the medical treatment.³⁴ "Futility" refers to the likelihood that medical treatment will serve principally to prolong the process of dying.³⁵ Unlike an ineffective treatment that fails to accomplish its purpose, a futile treatment may accomplish its purpose, but it will not benefit the patient in any way.³⁶

To the denial of death, we must add the delusion of medical immortality—the widespread belief that the available technology has made death optional. A prominent Stanford medical researcher confidently proclaimed at a conference, 'death is one more disease to be conquered.' Daniel Callahan comments, it is regrettable that 'death has been hidden of late under the weight of a technological medicine that would treat it as a kind of correctable accident, not a reality to be accepted as a fixed and necessary part of life.' ... [A]cceptance of the naturalness of dying . . . directly conflicts with the medicalization and legalization of death that characterizes modern society's treatment of dying elderly patients. We prefer instead to believe that dying results from disease and injury, which may yield to advances in medical technology. The progressive move of dying out of the home and into acute and long-term care facilities suggests that medicalization may be an irreversible process."

Id.

³¹Jeanine Lewis, *Health and Welfare: Chapter 658: California's Healthcare Decisions Law*, 31 MCGEORGE L. REV. 501, 505 (2000).

³²*Leach I*, 426 N.E.2d at 812. ("Edna Marie Leach is going to die. She is on the threshold of death, and man has, through a new medical technology, devised a way of holding her on that threshold. The basic question is how long will society require Mrs. Leach and others similarly situated to remain on the threshold of certain death suspended and sustained there by artificial life supports.")

³³*See* Young, *supra* note 26, at 271 n.16 (stating that "[q]uantitative futility suggests a treatment has not been statistically efficacious and is almost certainly not going to work if it is tried again. Qualitative futility focuses on whether the proposed treatment offers any benefit to the patient. Patients unable to appreciate any benefit of a treatment are receiving 'futile' therapy. Qualitative futility is more controversial, since it involves quality-of-life judgments. It should be noted that care is never futile, but certain treatments may be.").

³⁴*Id.* at 271-72 ("Situations of medical futility arise when, from the perspective of the treating team, three conditions are present. First, further aggressive therapy would not benefit the patient, violating the biomedical ethical principle of beneficence. Second, aggressive therapy would serve only to meaninglessly prolong an inevitable process of dying, denying the biomedical ethical principle of nonmaleficence. Third, therapy would squander finite and even shrinking societal resources, contravening the principle of distributive justice.").

³⁵*Id.*

³⁶The term "futile" should be distinguished from "ineffective." *See generally* Lainie Rutkow Notes, *Dying to Live: The Effect of the Patient Self-Determination Act on Hospice Care*, 7 N.Y.U. J. LEGIS. & PUB. POL'Y 393, 428 – 29 (2004) ("Unlike an ineffective treatment, a futile procedure or therapy may accomplish what it is designed to do. The result

For example, in the case of Edna Leach, administration of a respirator to facilitate breathing could be deemed “futile” because its primary purpose was to prolong the biological process of dying.³⁷ While the ventilation accomplished its functional purpose of mechanically maintaining Edna’s respiratory function, it was not medically beneficial to her because she was in a terminal, vegetative state without hope of recovery. Similarly, the administration of an artificial feeding tube was also a futile treatment in Edna’s case. Like the ventilation treatment, artificial hydration was intended only to facilitate the prolongation of her life.³⁸ None of these life-sustaining measures could have cured her illness or rendered her healthy once again. Rather, these measures merely delayed biological and physiological death.³⁹

Unfortunately, futile life-sustaining medical treatment is frequently administered in health care settings. The reason for doing so is that health care providers fear medical malpractice lawsuits from a patient’s loved ones for not taking every possible measure available to prevent the patient from dying.⁴⁰ This fear of malpractice liability increases the potential that providers will administer futile medical treatments and therefore, the desire to avoid the administration of futile medical treatment is a primary motivation for patients who execute advance directives.

Another motivation for executing written advance directives is the desire to provide written documentation to one’s health care provider regarding medical treatment wishes. Sometimes health care providers are faced with the difficult situation, both legally and emotionally, when the patient’s family disagrees with the patient’s wishes, and the family attempts to assert their own beliefs in place of the patient’s desires.⁴¹ In the absence of a legally executed written declaration, oftentimes the health care provider will be forced to pursue the course of treatment that satisfies the family members’ wishes.⁴² By providing a legally executed written

of the treatment, however, is of no help to a given patient. In other words, ‘[a] judgment of futility is, strictly speaking, not the judgment that an intervention will be harmful, but only that it will not be beneficial.’”).

³⁷See generally *Leach I*, 426 N.E.2d at 812; *Leach II*, 469 N.E.2d at 1047.

³⁸*Id.*

³⁹*Id.*

⁴⁰See Young, *supra* note 26, at 271 (stating that “[d]isagreements within families can make timely and appropriate decision-making for incapacitated patients without advance directives all but impossible. For example, where a son is asking that aggressive therapy be withdrawn, and a daughter is threatening litigation unless ‘everything be done,’ the treatment team will invariably maintain the status quo until the family is able to speak with a single voice. Reconciliation of family members’ disparate views of what the patient would have wanted can sometimes occur; but, where there is a long history of division within the family, reconciliation may not be possible. In such circumstances, the treating team will usually ‘play it safe,’ and maintain a conservative course which may not necessarily be in the patient’s best interests.”).

⁴¹*Id.*

⁴²Marshall B. Kapp, *Legal Anxieties and End-of-Life Care in Nursing Homes*, 19 ISSUES L. & MED. 111, 119 (2003) (“‘Dead patients don’t sue, but live families do,’ ‘Doing what the family demands is the path of least legal resistance,’ and ‘Do what the family wants and wait

advance directive for the patient's hospital record, the health care provider can ensure that the patient's wishes are being advanced, as opposed to the wishes of the family members.

B. The "Evolution" of CPR and Its Impact at the End of Life

Cardiopulmonary resuscitation ("CPR") is a procedure that was invented for the purpose of restoring a person's respiratory functions after a person suffers a cardiac arrest; it incorporates the "clearance of air passages to the lungs, mouth-to-mouth method of artificial respiration, and heart massage by the exertion of pressure on the chest."⁴³ CPR was invented in the 1950's for the purpose of restoring respiratory and cardiac functions to persons suffering a cardiac arrest as a result of electrocution, anesthesia, or heart attack.⁴⁴

The American Heart Association's⁴⁵ 2005 Guidelines identified three instances in which CPR should not be initiated on a patient: 1) the patient has a valid Do Not Resuscitate order; 2) the patient is already dead, or is showing physical signs of irreversible death; and 3) the patient will not receive any physiological benefit from CPR because vital bodily functions have deteriorated despite comprehensive therapy.⁴⁶ The third category encompasses elderly patients suffering from terminal illness or degenerative, disabling diseases, with little to no chance of recovery; such was the case with Edna Leach.⁴⁷

for nature to solve the problem' are veritable mantras among attending physicians, medical directors, and other nursing home personnel.").

⁴³Dictionary.com, <http://www.merriam-webster.com/cgi-bin/mwmedsamp>.

⁴⁴Paul C. Sorum, *Limiting Cardiopulmonary Resuscitation*, 57 ALB. L. REV. 617 (1994).

⁴⁵General information regarding the American Heart Association ("AHA") and its purpose, history, organizational structure and policies, can be found at the AHA's official website, www.americanheart.org. The American Heart Association is a "national voluntary health agency whose mission is to reduce disability and death from cardiovascular diseases and stroke." *Id.*

⁴⁶*See* the American Heart Association's 2005 Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular care, Part 2: Ethical Issues, *available at* http://circ.ahajournals.org/cgi/content/full/112/24_suppl/IV-6.

⁴⁷For a detailed analysis of the lack of effectiveness and high economic costs of cardiopulmonary resuscitation ("CPR"), *see generally* Sorum, *supra* note 44, at 621-22.

The American Heart Association . . . distinguishes three categories of patients for whom CPR might be deemed of no medical benefit: 1) the patient who, for practical purposes, is already dead . . . 2) the patient whose cardiac arrest is the culmination of a relentlessly deteriorating and terminal condition - for example, a patient in an intensive care unit who is receiving maximal therapy but whose blood pressure or oxygen level is nonetheless progressively falling; and 3) the patient whose serious underlying disease puts him or her in a category in which survival after an arrest and resuscitation until discharge from the hospital would be unprecedented, or, as others would insist, a category in which survival is rare if not actually unprecedented - for example, a patient with widely metastatic cancer, multiple organ failure, or sepsis. The first two categories, in which the futility of CPR is obvious, need not concern us much. . . . The real debate about futility thus narrows down to whether CPR can be deemed futile in the third scenario where survival to hospital discharge would be unprecedented or at least rare, as in fact the American Heart Association and the other

In cases where patients in this third category receive CPR following a cardiac arrest, the resuscitation is likely to be a futile and possibly brutal treatment⁴⁸ and thus, implicates ethical considerations regarding the administration of CPR. As one writer noted, patients in this third category who do receive CPR and are resuscitated are left in a medically “worse off” position than having not been resuscitated in the first instance.⁴⁹ CPR was never intended to be administered to terminally ill patients with no hope of recovery.⁵⁰ Not long after its inception, however, CPR became a standard treatment for all patients:

[CPR] was invented . . . primarily for patients who, because of shocks from electrical lines . . . or heart attacks, developed ventricular fibrillation - the sudden onset of chaotic electrical activity in the muscle wall of the ventricle . . . [b]ut quickly it was used . . . on patients without ventricular fibrillation as well, that is, on types of patients for whom it was not originally intended. Soon everyone in the hospital was . . . a candidate for CPR, even when the cause of the arrest was chronic, not acute. CPR became a right for all patients, although a rite of passage to death for most.⁵¹

CPR was not intended for use on elderly patients whose bodies have succumbed to a degenerative disease with little chance of recovery. In cases such as these, where CPR is successfully administered and restores cardiac and respiratory functions, the next step that often follows is the administration of life-sustaining medical technologies, such as ventilators and nasogastric tubes to enable artificial nutrition, as was the case with Edna Marie Leach.

The increase in the administration of CPR on elderly patients in the medical setting necessarily increases the likelihood of patients having to confront the issue of

major proponents of the futility argument have claimed. This is indeed an important issue, for with this third category of patients, unlike with the first two, we are facing potentially enormous psychological and economic costs.

⁴⁸Rutkow, *supra* note 36, at 414-15 (stating that “[p]atients in hospice are among the sickest patients in any health care facility; their bodies are usually very frail . . . [f]or a terminally ill patient, [CPR] can be a brutal procedure. The following account describes a medical resident’s experience administering CPR to an 84-year-old woman with heart and kidney failure who experienced cardiac arrest: ‘I thrust down on her chest repeatedly. With each stroke, her frail ribs snapped under my weight. Someone else prodded her neck and groin, jabbing needles into her to gain IV access. A tube was jammed down her throat and blood oozed from her mouth. We all stood back and watched as the defibrillator sent electrical shocks ripping through her. We kept this up for 30 minutes. She was then declared ‘officially’ dead.’”).

⁴⁹See Sorum, *supra* note 44, at 618-19 (“The results of CPR in adults are not encouraging. Most patients die either immediately or within a few days. Only about a tenth of recipients live long enough to leave the hospital. It seems, therefore, that CPR is a highly atypical medical procedure in that most patients are worse off after it than before it.”).

⁵⁰*Id.* at 617-18. (combined with this generalized “loathing” of legal processes, there has been a drastic increase in liability insurance rates for nursing homes . . . in Ohio alone, nursing home insurance liability premiums increased a whopping thirty percent overall from 2000 through 2001.)

⁵¹*Id.*

the use of life-sustaining medical treatments. Thus, the increase in administration of CPR has increased the need for patients to execute advance directives declaring what types of life sustaining treatments a patient may or may not want to receive.

C. Medical Malpractice Liability Influences the Provider's Decision of Whether to Administer Futile Medical Treatment

When a health care provider determines the course of treatment to be administered to a patient, the provider will often choose the treatment option that presents the lowest risk of a medical malpractice suit, even if that treatment option would be medically futile. Often, health care providers will administer futile life-sustaining treatment solely because the provider fears that foregoing such treatment will instigate a medical malpractice lawsuit on behalf of emotionally charged family members. Thus, while the number of medical malpractice lawsuits is increasing, an advance directive executed in compliance with statutory requirements assures health care providers that they will be shielded from malpractice liability for following a patient's wishes regarding desired treatment.

Malpractice liability is an increasingly important factor that arises in end of life medical treatment decisions. As one writer noted, "a certain amount of generalized fear and loathing of anything connected to the law, lawyers, or the legal process is innate among all health care providers, especially in the [end of life] context."⁵²

Under Ohio law, in the case of a patient who does not have an advance directive and is facing end of life medical treatment decisions, the patient's spouse is the first in line to make decisions on behalf of the patient.⁵³ If the patient does not have a surviving, competent spouse, the patient's adult child will then make medical treatment decisions on the patient's behalf.⁵⁴ However, where the patient has more than one adult child, the majority of the patient's adult children who are available must agree on the medical treatment decision or course of treatment at issue.⁵⁵

Where the patient's children are not in agreement with either the doctor's recommended course of treatment or with each other, health care providers, when choosing the course of treatment to be administered, will often choose the path that presents the lowest risk of a medical malpractice suit.⁵⁶ Indeed, even where a health care provider determines that providing a certain type of end of life medical treatment to a patient would be futile and only prolong the process of dying, if the patient's adult child or children demand aggressive life prolonging medical

⁵²See Kapp, *supra* note 42, at 118-19.

⁵³OHIO REV. CODE ANN. § 2133.08 (B) (2) – (6) (West 1991) (stating, in part, that the descending order of persons who have priority in making end of life treatment decisions on behalf of a patient who does not have a written declaration of the patient's wishes: "The patient's spouse . . . [a]n adult child of the patient or, if there is more than one adult child, a majority of the patient's adult children who are available within a reasonable period of time for consultation with the patient's attending physician . . . [t]he patient's parents . . . [a]n adult sibling of the patient or, if there is more than one adult sibling, a majority of the patient's adult siblings who are available within a reasonable period of time for such consultation.").

⁵⁴*Id.*

⁵⁵*Id.*

⁵⁶See generally Kapp, *supra* note 42.

treatment, the child's demand "virtually always controls the situation regardless of how inappropriate that demand may be."⁵⁷

As one writer observed, health care providers administer end of life treatment on the presumption that:

[A]ngry consultation with an attorney is the inevitable next step after family dissatisfaction. The perception that the family is always looking over the providers' shoulders is exacerbated by the knowledge that adult children often are irrational because they feel guilty and conflicted about the parent being in a nursing home in the first place, and these emotions are compounded when the parent is in the midst of dying. Several medical directors interviewed spoke about inappropriately placing feeding tubes in dying residents in order to "feed the family," so that the family would be able to say later, "[w]e did everything we could, but Mom died anyway so it must be God's will." In some circumstances, a [family member] refuses to make treatment decisions one way or the other; in such circumstances, it is almost universally viewed by nursing home providers as legally safest to err on the side of inflicting aggressive [life sustaining medical treatment] on the dying resident.⁵⁸

Because health care providers will likely be motivated to pursue treatment options that pose the path of the least legal resistance, advance directives will often prove to be a more reliable method for patients to communicate their wishes rather than expecting that their wishes will be effectuated through the advocacy of their spouses or children.⁵⁹ Perhaps of even greater importance from a provider's perspective, health care providers who follow a patient's legally executed advance directive will be shielded from liability in the event that the patient's family members disagree with the patient's decisions regarding end of life medical treatment. Thus, an advance directive not only expressly communicates a patient's wishes, but it could likely prevent a physician from ignoring the patient's wishes out of fear that doing so will result in a lawsuit filed by the patient's disgruntled family members.

D. Conclusion of the Growing Need for Advance Directives

Advancements in medical treatments, combined with the increased number of people who die in health care settings as opposed to their own homes, carry the risk that many patients will be faced with decisions of whether or not to forego life-sustaining medical treatment and has increased the need for advance directives.

⁵⁷*See id.* at 119.

⁵⁸*Id.* at 119-20.

⁵⁹*Id.* ("The widespread notion that courts routinely interfere with EOL decision making and always in the direction of ordering or approving aggressive life-sustaining medical treatment . . . coupled with broad fear of regulatory sanctions for providing too little aggressive life-sustaining medical treatment but never for trying too hard to cure dying residents, often contributes to inappropriately aggressive resuscitation attempts and excessive use--both initially and on a continuing basis--of feeding tubes in the nursing home. Action, or "doing something," is equated with good defensive medicine, even (maybe especially) in [end of life] situations when it is destined to be non-beneficial.")

While competent patients can orally consent to or refuse medical treatment, incompetent persons are legally incapable of doing so. Advance directives provide a mechanism by which competent persons can expressly state which medical treatments to accept or refuse in the future, in the event that the person becomes incompetent due to disease or injury. Advance directives empower a patient to retain the right to consent to or refuse futile and possibly brutal medical treatments such as CPR, mechanical respiration and artificial hydration. Moreover, a legally executed advance directive assures health care providers that they will be shielded from malpractice liability for following a patient's documented wishes regarding treatment, even at the risk of angering a patient's family members.

III. HISTORY OF THE RIGHT TO REFUSE MEDICAL TREATMENT

The common law doctrine of informed consent is deeply rooted in American jurisprudence. The United States Supreme Court has recognized a patient's right to refuse medical treatment as a logical corollary of the doctrine of informed consent for over 100 years. Because informed consent is a doctrine firmly entrenched in American law, the Court has recognized that both competent and incompetent patients alike share the right to the refuse unwanted medical treatment.⁶⁰ However, states have not uniformly codified this right within the context of advance directive statutes. Although the United States Supreme Court has recognized a patient's right to refuse treatment, analysis of the Ohio Revised Code advance directive statutes reveals that a patient's right to refuse life-sustaining medical treatment in Ohio may actually be harmed by the Code, rather than protected by it.

A. *History of the Right to Refuse Medical Treatment Outside of Ohio*

As early as 1891, the United States Supreme Court recognized that "[n]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others."⁶¹ In 1914, Justice Cardozo articulated the doctrine of informed consent by stating "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault,

⁶⁰*Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 269 (1990) (stating that "the informed consent doctrine has become firmly entrenched in American tort law").

⁶¹*Union Pacific Ry. Co. v. Botsford*, 141 U.S. 250, 252 (1891) (refusing to compel plaintiff to endure a medical examination regarding the injury that formed the basis of her cause of action, stating that to compel someone to submit to "the touch of a stranger, without lawful authority, is an indignity, an assault and a trespass") ("No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."). *Id.* at 251. More recently, the Supreme Court reiterated this position by holding that a competent person has a liberty interest under the Due Process Clause in refusing unwanted medical treatment. *See generally Cruzan*, 497 U.S. at 278-80.

for which he is liable in damages.”⁶² Accordingly, the doctrine of informed consent conversely entails the right “not to consent” to medical treatment.⁶³

For the next sixty years, the common law doctrine of informed consent evolved rather slowly. Evolution of this doctrine primarily occurred within the context of an incompetent mental health patient’s right to refuse psychiatric treatment.⁶⁴ By 1976, state supreme courts began recognizing the right to refuse medical treatment even when the refusal would result in death.⁶⁵ In the case of *In re Quinlan*, the New Jersey Supreme Court held that the constitutional right to privacy encompasses a “patient’s decision to decline medical treatment.”⁶⁶

In 1990, the United States Supreme Court decided to confront the issue of the right to refuse medical treatment.⁶⁷ In the case of *Cruzan*,⁶⁸ the Court held that a competent person has a liberty interest under the Due Process Clause in refusing unwanted medical treatment: “a competent person [has] a constitutionally protected right to refuse lifesaving hydration and nutrition.”⁶⁹ While noting that incompetent patients have the same rights as competent patients to refuse unwanted treatment because both groups are entitled to the same value of human dignity. The *Cruzan* court noted that in the case of an incompetent patient, individual states have the right to establish procedural safeguards to properly protect and ascertain what decisions the patient would choose if the patient were competent to do so.⁷⁰

Although the United States Supreme Court recognized a patient’s right to refuse unwanted medical treatment as constitutionally protected, and found this right to be deeply embedded within the common law doctrine of informed consent, the states

⁶²*Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

⁶³*Cruzan*, 497 U.S. at 270. For an analysis of the legal history of the informed consent doctrine, see generally Nancy M.P. King, *Consent and the Courts: The Emergence of the Legal Doctrine*, in RUTH R. FADEN ET AL., *A HISTORY AND THEORY OF INFORMED CONSENT* (1986).

⁶⁴Bruce J. Winick, *Advance Directive Instruments for Those with Mental Illness*, 51 U. MIAMI L. REV. 57, 58 (1996) (citing Alexander D. Brooks, *LAW, PSYCHIATRY AND THE MENTAL HEALTH SYSTEM* 609-18 (1974)).

⁶⁵*In re Quinlan*, 355 A.2d 647, 663 (N.J. 1976) (recognizing that the unwritten constitutional right to privacy “is broad enough to encompass a patient’s decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman’s decision to terminate pregnancy under certain conditions.”). Over the past thirty years, courts have recognized a right to refuse treatment based on either the common law doctrine of informed consent or on a constitutional privacy right. *Cruzan*, 497 U.S. at 271.

⁶⁶*Quinlan*, 355 A.2d at 663.

⁶⁷*Cruzan*, 497 U.S. at 261.

⁶⁸*Id.*

⁶⁹*Id.* at 278-80 (citing *cf., e. g., Jacobson v. Mass.*, 197 U.S. 11, 24-30 (1905)); *Id.* at 278-80 (basing this determination on its previous declaration that “[n]o right is held more sacred . . . than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.”).

⁷⁰*Id.* at 279-82.

have not uniformly recognized this right within the context of advance directive statutes. Instead, the respective states' legislatures have remained disjointed in their differing approaches to advance directive laws.

B. History of the Right to Refuse Medical Treatment in Ohio

Ohio's history of the right to refuse life-sustaining treatment began with the 1982 *Leach* case. In 1984, Ohio's Ninth District Court of Appeals declared that a patient had an absolute right to refuse life-sustaining medical treatment unless a court determined that the state's interests outweighed the patient's individual interests. In 1991, Ohio adopted the Uniform Rights of the Terminally Ill Act which codified the use and execution of advance directives and, regrettably, also adopted a civil and criminal immunity statute which protected health care providers from legal liability for non-compliance. By 1996, the Ohio Supreme Court issued a confusing, almost contradictory opinion in *Anderson* where it both recognized the right of a patient to refuse medical treatment as one rooted within the informed consent doctrine and refused to allow a patient to recover damages for a violation of this right, reasoning that to permit recovery would be analogous to recognizing the controversial wrongful living cause of action. Currently, there has been no guidance. Analysis of Ohio's common law shows that the past twenty-five year history of an Ohio patient's right to refuse life-sustaining medical treatment warrants further evolution.

1. The *Leach* Case

The 1981 death of Edna Marie Leach spawned the first case in Ohio that dealt with the issue of a patient's legal right to be removed from life support.⁷¹ In 1982,⁷² Edna's family brought suit against the treating hospital, alleging the following: Edna Leach was placed on life support without the consent of her family; the hospital failed to advise the Leach family on the nature of Edna's medical condition; and during the two month period that Edna was on life support, the hospital administered experimental medical treatments to Edna without her family's consent.⁷³ At that time, there was no applicable Ohio statutory or case law in effect with which to guide the *Leach* court.⁷⁴ Rather, the court relied on case law from other states that had recently addressed the issue of an incompetent, terminally ill patient's right to refuse treatment.⁷⁵ The court recognized a constitutionally based right to refuse treatment as part of the right to privacy, and thus, issued a court order directing the hospital to discontinue life support. However, the court dismissed the Leachs' tort claims for failure to state a claim upon which relief can be granted, because Ohio law

⁷¹*Leach v. Akron Gen. Med. Ctr.*, 426 N.E.2d 809, 812 (Summit County Ct. Com. Pl. 1980).

⁷²*Estate of Leach v. Shapiro*, 469 N.E.2d 1047, 1051 (Ohio Ct. App. 1984).

⁷³*Id.* at 1052, 1054.

⁷⁴*Leach I*, 426 N.E.2d at 812.

⁷⁵*Id.* at 812-13. ("While considerable law exists on the question of treatment, only five states have addressed the question as posed to this court, that is, treatment of the terminally ill, incompetent individual.") (citations omitted).

at the time required health care providers to obtain a court order before life-support could be discontinued.⁷⁶

On appeal in 1984, Ohio's Ninth District Court of Appeals reinstated the Leach family's claims for non-disclosure, pain and suffering, mental anguish, and punitive damages.⁷⁷ The court affirmed the dismissal of the invasion of privacy claim, reasoning that this was a personal right that lapsed upon the patient's death.⁷⁸ The court held that a patient has an absolute right to refuse medical treatment unless competing state interests outweigh the patient's individual rights after being evaluated in court proceedings.⁷⁹ Since a patient's right to refuse medical treatment is a "logical extension of the consent requirement ... [and] the existence of consent, either express or implied, is a question of fact,"⁸⁰ the case was remanded to the trial

⁷⁶*Leach II*, 469 N.E.2d at 1051. (stating that "[o]n July 9, 1982, plaintiffs filed this action seeking damages for the time Mrs. Leach was on life support systems. Defendants filed a motion in the alternative, to dismiss or for summary judgment. This motion was not supported by affidavits or other evidence. Civ. R. 12(B) provides that a Civ. R. 12(B)(6) motion may be converted to a motion for summary judgment, but requires that both parties be afforded the opportunity to present evidence pertinent under Civ. R. 56. The court did not permit or receive additional evidence, but, instead, treated defendants' motion as one to dismiss for failure to state a claim upon which relief may be granted. The court granted defendants' motion and plaintiffs appeal."). *Id.*

⁷⁷*See generally id. at 1047.*

⁷⁸*Id.* at 1054. ("The right to privacy is a right personal to the individual asserting it. This right lapses with the death of the person who enjoys it and the decedent's heirs may not recover for the invasion.") (citations omitted).

⁷⁹*Leach II*, 469 N.E.2d at 1051 – 52 ("While the patient's right to refuse treatment is qualified because it may be overborn (sic) by competing state interests, we believe that, absent legislation to the contrary, the patient's right to refuse treatment is absolute until the quality of the competing interests is weighed in a court proceeding. We perceive this right as the logical extension of the consent requirement and conclude that a patient may recover for battery if his refusal is ignored.").

⁸⁰*Id.* at 1052. The court discussed the nature of the implied consent doctrine, as well as the impact of implied consent on that doctrine.

Not only must a patient consent to treatment, but the patient's consent must be informed consent. There is no legal defense to battery based on consent if a patient's consent to touching is given without sufficient knowledge and understanding of the nature of the touching. The requirement of informed consent has its roots not only in the patient's right to privacy but also in the nature of the physician-patient relationship. The physician owes his patient a fiduciary duty of good faith and fair dealing which gives rise to certain specific professional obligations. These obligations include not only the duty to exercise due care and skill, but to fully inform the patient of his condition and to obtain the patient's informed consent to the medical treatment. While consent to a procedure is always required, courts have appreciated that circumstances may render the patient's consent impossible or impracticable to obtain. Where the patient is not competent to consent, an authorized person may consent in the patient's behalf. In other circumstances the patient's consent, though not expressly given, will be implied. Such circumstances must amount to more, however, than the mere inability of the patient to consent. Express consent to treat a specific condition through a surgical procedure may imply consent to all procedures necessary to achieve that end, but not to procedures clearly not contemplated within the original consent.

court for factual determinations.⁸¹ The appellate court concluded that because the nature and existence of any consent rendered on behalf of the patient were determinative as to whether the plaintiff was entitled to damages, the trial court erred in dismissing plaintiff's claims for failure to state a known cause of action.⁸² The trial court did not, however, have the opportunity to hear the case on remand because the defendant-hospital settled with the plaintiffs out of court.⁸³

2. The Modified Uniform Rights of the Terminally Ill Act

Following *Leach*, Ohio adopted the Modified Uniform Rights of the Terminally Ill Act ("Act")⁸⁴ in 1991.⁸⁵ The Act governs the use of advance directives⁸⁶ and withdrawal of life-sustaining treatment.⁸⁷ While the Act sets forth provisions for

The patient's consent will also be implied where the patient is unable to consent and there exists some emergency requiring immediate action to preserve the life or health of the patient. The existence of consent, either express or implied, is a question of fact.

Id. (citations omitted).

⁸¹*Id.* at 1051. "A court may only grant a Civ.R. 12(B)(6) motion when it appears beyond doubt from the complaint that plaintiff can prove no set of facts which would entitle him to relief. Under this standard we must reverse the trial court's decision. *Id.* (citation omitted).

⁸²*Id.* at 1053–54.

The merits of plaintiffs' claims for relief depend upon the facts that are developed in this case. The existence and nature of any consent, the existence and nature of any refusal of treatment, the nature of the treatments before August 1, 1980, Mrs. Leach's condition on August 1, 1980, and the nature of the treatment on and after August 1, 1980, are all factual questions the answer to which determine whether plaintiffs are entitled to relief. Accordingly, defendants' motion to dismiss Count 1 for failure to state a claim should not have been granted." *Id.* The appellate court did, however, affirm the trial court's dismissal of plaintiff's right to privacy claim because the claim died with the patient, Edna Marie Leach. *Id.* "Plaintiffs seek to recover damages for defendants' alleged conduct which invaded Mrs. Leach's right to privacy. The right to privacy is a right personal to the individual asserting it. This right lapses with the death of the person who enjoys it and the decedent's heirs may not recover for the invasion. Accordingly, the dismissal of this cause of action was proper."

Id. at 1054. (citations omitted).

⁸³Vicki Joiner Bowers, Elder Law Symposium, Comment, *Advance Directives: Peace of Mind or False Security?*, 26 STETSON L. REV. 677, n.138 (1996).

⁸⁴1991 Ohio Legis. Bull. 159, 166-76 (LexisNexis) (codified as OHIO REV. CODE ANN. § 2133.01 - .15 (2006)). For a detailed analysis of the Uniform Rights of the Terminally Ill Act and the Uniform Health Care Decisions Act as adopted in the fifty states, see generally Horrtor, *supra* note 19.

⁸⁵See generally Horrtor, *supra* note 19.

⁸⁶For a detailed discussion regarding the Modified Rights of the Terminally Ill Act and its implications in Ohio, see generally Julie C. Vieson, *Living Will Legislation in Ohio: The Modified Uniform Rights of the Terminally Ill Act*, 61 U. CIN. L. REV. 969 (1993).

⁸⁷OHIO REV. CODE ANN. § 2133.01 (West 2006) (defining life-sustaining treatment as "any medical procedure, treatment, intervention, or other measure that, when administered to a qualified patient or other patient, will serve principally to prolong the process of dying.").

executing advance directives, it does not guarantee that a patient's advance directive will actually be honored in a health care setting. In reality, the Act codifies civil and criminal immunity for health care providers who do not abide by a patient's advance directive.⁸⁸ As a result, the Act affords patients in Ohio no greater protection of the right to refuse medical treatment through the use of an advance directive than patients had before the Act was ratified.

The Act defines life-sustaining treatment as medical treatment that, "when administered to a qualified patient...will serve principally to prolong the process of dying."⁸⁹ While the Act prescribes execution requirements that must be met in order for the directive to be operative, it does not require a physician to obey a properly executed directive.⁹⁰ On the contrary, health care providers in Ohio are granted civil and criminal statutory immunity for refusing to comply with a patient's advance directive "on the basis of a *matter of conscience or on another basis*[,]"⁹¹ so long as the provider does not delay the transfer of the patient to a provider who is willing to comply.⁹² The Act does not, however, define the terms 'matter of conscience' or 'another basis,' leaving such interpretations up to health care providers themselves.⁹³ Nor does the Act state a time frame in which the transfer to a complying provider must take place.⁹⁴ Furthermore, the Act does not provide guidelines for how aggressively a provider must seek out a complying physician.⁹⁵

The Act, while providing guidelines for the execution of advance directives, does not afford patients today any greater protection of the right to refuse medical treatment than Edna Leach had. The Act does not lessen the potential for injury to be inflicted upon the patient and the patient's family by not abiding by a patient's wishes to refuse medical treatment, as was the case with Edna Leach. The Act uses overly broad language which would allow a health care provider to substitute the

⁸⁸OHIO REV. CODE ANN. § 2133.02 (D) (1) (West 2006).

[A]n attending physician of a declarant or a health care facility in which a declarant is confined may refuse to comply or allow compliance with the declarant's declaration on the basis of a matter of conscience or on another basis. An employee or agent of an attending physician of a declarant or of a health care facility in which a declarant is confined may refuse to comply with the declarant's declaration on the basis of a matter of conscience.

Id.

⁸⁹OHIO REV. CODE ANN. § 2133.01 (Z) (West 2006) (defining a "qualified patient" as "an adult who has executed a declaration and has been determined to be in a terminal condition or in a permanently unconscious state."); OHIO REV. CODE ANN. § 2133.01 (Q) (West 2006) (defining life-sustaining treatment as any medical procedure, treatment, intervention, or other measure that, when administered to a qualified patient or other patient, will serve principally to prolong the process of dying).

⁹⁰*See generally* OHIO REV. CODE ANN. § 2133.01-15; § 2133.03 (West 2006).

⁹¹§ 2133.02 (D) (1) (emphasis added).

⁹²OHIO REV. CODE ANN. § 2133.10 (A) (West 2006).

⁹³OHIO REV. CODE ANN. § 2133.01; § 2133 (D) (1) (West 2006).

⁹⁴*See generally* § 2133.01-15.

⁹⁵*Id.*

provider's beliefs regarding medical treatments in the place of a patient's, or patient's family's own wishes.

IV. INSUFFICIENT COMMON LAW CAUSES OF ACTION IN OHIO

While statutory immunity for health care providers is a serious impediment to the enforcement of one's right to autonomy in Ohio, it is not the only barrier. Analysis of Ohio law through *Anderson*, *Allore*, and *Perkins* demonstrates that the common law causes of action of negligence, battery and intentional infliction of emotional distress are inefficient remedies to compensate a patient whose advance directive has been violated.⁹⁶

A. Negligence

Interference with a person's rights can either be intentional or negligent.⁹⁷ To establish a prima facie case of negligence against a health care provider, the plaintiff must establish the elements of duty, breach, causation, and damages. Interference with a patient's right to refuse medical treatment constitutes a breach of a physician's duty to honor a patient's wishes.⁹⁸ Where a negligence suit is filed against a non-complying provider on behalf of a patient whose advance directive was disregarded, in order for a plaintiff to establish the breach of duty element, the plaintiff must establish that the provider's failure to abide by an advance directive was a deviation from the relevant standard of conduct.⁹⁹ The relevant standard of conduct is "that of a reasonable specialist practicing medicine . . . in the light of present day scientific knowledge in that specialty field."¹⁰⁰

The *Allore* court effectively denied recovery to a plaintiff because the plaintiff failed to establish the breach of duty element.¹⁰¹ The court specifically found that reasonable minds could not disagree that the health care providers did not deviate from the relevant standard of care. By examining the relevant standard of conduct of

⁹⁶One commentator has noted that unlike the right to refuse medical treatment, a "review of other fundamental rights shows that courts have upheld the protection of individual liberties and autonomy rights, even when they disagree with how the individual exercises those rights or see potentially harmful consequences following such an exercise." S. Elizabeth Wilborn Malloy, *Beyond Misguided Paternalism: Resuscitating the Right to Refuse Medical Treatment*, 33 WAKE FOREST L. REV. 1035, 1079 (1998) (comparing the right to refuse medical treatment with a woman's right to abortion and a citizen's right to vote).

⁹⁷*Anderson v. St. Francis-St. George Hosp.*, 671 N.E.2d 225, 227 (Ohio 1996) (stating that a "medical professional who has been trained to preserve life, and who has taken an oath to do so, is relieved of that duty and is required by a legal duty to accede to a patient's express refusal of medical treatment. Whether intentional or negligent, interference with a person's legal right to die would constitute a breach of that duty to honor the wishes of the patient. Where a breach of duty has occurred, liability will not attach unless there is a causal connection between the conduct of the medical professional and the loss suffered by the patient.").

⁹⁸*Id.*

⁹⁹*Allore v. Flower Hosp.*, 699 N.E.2d 560, 561-63 (Ohio Ct. App. 1997).

¹⁰⁰*Bruni v. Tatsumi*, 346 N.E.2d 673 (Ohio 1976).

¹⁰¹*Allore*, 699 N.E.2d at 562, 564.

a “reasonable specialist,” the focus shifts away from the patient’s right to refuse medical treatment to determining the acceptable standard within the medical community. The very nature of this inquiry contradicts the principle of the informed consent doctrine that an autonomous patient has a right to refuse treatment, even if the refusal is harmful, unreasonable or even irrational. Thus, if a patient decides to refuse medical treatment and a physician determines that such a refusal is harmful to the patient’s health, the “reasonable specialist” could override the patient’s own wishes and exercise wishes more consistent with those of a “reasonable specialist” in the medical community.

The *Anderson* court denied recovery to a plaintiff based on the breach of duty, causation, and damages elements of a negligence claim. Specifically, the court reasoned that it would be difficult to determine what damages are caused by the harm of resuscitation, and refused to recognize the plaintiff’s prolonged life as a type of compensable harm traditionally associated with the damages element of a negligence cause of action. A closer analysis of *Anderson* and *Allore* clearly show that a negligence cause of action is an inadequate remedy to compensate a patient whose advance directive has been violated.

1. *Allore v. Flower Hospital*

In *Allore v. Flower Hospital*, the plaintiff was unsuccessful in her attempt to recover damages from the defendant-hospital for resuscitating the plaintiff’s deceased husband, where the resuscitation was expressly proscribed in his living will.¹⁰² The plaintiff alleged that by disregarding her decedent husband’s wishes as contained in his living will, the health care providers employed by the defendant-hospital were negligent in their care of her husband.¹⁰³ The plaintiff’s suit was based on four claims: negligence and battery on behalf of her deceased husband; loss of consortium and severe emotional distress on her own behalf.¹⁰⁴ The plaintiff’s negligence cause of action specifically alleged that the hospital staff’s disregard for the decedent’s wishes as expressed though his living will constituted medical negligence.¹⁰⁵

Plaintiff’s decedent-husband, Frank Allore, was diagnosed with asbestosis in 1976.¹⁰⁶ Dr. Nasir Ali, the decedent’s primary care physician and pulmonologist, treated decedent until his death on August 24, 1994.¹⁰⁷ During a June 1994 hospitalization, the decedent executed both a living will and a durable power of attorney for health care (“DPOAH”).¹⁰⁸ The decedent’s DPOAH designated his wife, Mary, to make health care decisions on his behalf in the event that he was unable to do so.¹⁰⁹ The living will stated that decedent did not wish to receive ““life-sustaining

¹⁰²*Allore*, 699 N.E.2d at 560.

¹⁰³*Id.*

¹⁰⁴*Id.*

¹⁰⁵*Id.*

¹⁰⁶*Id.* at 561.

¹⁰⁷*Id.*

¹⁰⁸*Id.*

¹⁰⁹*Id.*

treatment' in the event that [he] suffered from a 'terminal condition' or was in a 'permanently unconscious state.'"¹¹⁰ Both the primary care physician, Dr. Ali, and Flower Hospital were aware that the decedent had executed these documents.¹¹¹

"On August 22, 1994, Frank Allore was again admitted to Flower Hospital with symptoms indicating tracheal bronchitis, severe chronic respiratory failure, and resolving congestive heart failure."¹¹² Upon his admission, the decedent's primary care physician, in lieu of a DNR order, placed the following order in the decedent's hospital chart: "In the event of cardiac standstill, ventricular fibrillation or respiratory arrest, resuscitation measures are to be initiated immediately using [advanced cardiac life support] protocols ([w]ith attention to written code status orders) . . . The physician will be notified immediately of any emergency interventions by nursing personnel."¹¹³

In the early hours of August 23, 1994, the decedent notified his attending nurse, Kim Perry, that he had difficulty breathing.¹¹⁴ After noticing pulmonary edema,¹¹⁵ Nurse Perry tested the decedent's blood oxygen level and subsequently contacted the decedent's primary care physician, Dr. Ali.¹¹⁶ However, Dr. Ali did not provide Nurse Perry with any instructions regarding the treatment of the decedent.¹¹⁷ After a subsequent assessment of decedent's condition, Nurse Perry became frustrated by Dr. Ali's failure to provide specific orders over the telephone regarding the decedent's respiratory distress; this combined with her belief that the decedent was suffering from a "cardiac problem," she called cardiologist Dr. Nahhas.¹¹⁸ At this point, neither Nurse Perry nor Dr. Nahhas was aware of the existence of the decedent's living will or DPOAH.¹¹⁹ Dr. Nahhas ordered the decedent to be transferred to the intensive care unit, intubated,¹²⁰ and placed on a mechanical ventilator.¹²¹ After learning of the decedent's living will later that day, Dr. Nahhas

¹¹⁰*Id.*

¹¹¹*Id.*

¹¹²*Id.*

¹¹³*Id.*

¹¹⁴*Id.*

¹¹⁵Pulmonary edema is defined as an "abnormal accumulation of fluid in the lungs." Merriam-Webster's Medical Dictionary Online, <http://www.merriam-webster.com/cgi-bin/mwmedsamp>.

¹¹⁶*Allore*, 699 N.E.2d at 561.

¹¹⁷*Id.*

¹¹⁸*Id.* at 562.

¹¹⁹*Id.* at 561.

¹²⁰Intubation is defined as "the introduction of a tube into a hollow organ ([such] as the trachea)." Merriam-Webster's Medical Dictionary Online, <http://www.merriam-webster.com/cgi-bin/mwmedsamp>.

¹²¹*Allore*, 699 N.E.2d at 562.

ordered the withdrawal of the decedent from the ventilator.¹²² Frank Allore died shortly thereafter.¹²³

The trial court found that resuscitating Frank Allore “was not a deviation from the accepted standards of physician and/or nursing care;” it found that the plaintiff did not meet her burden of establishing the breach element of her negligence cause of action. Consequently, the *Allore* court granted summary judgment in favor of the defendant-hospital on all four of plaintiff’s claims.¹²⁴ The plaintiff subsequently appealed.¹²⁵ Ohio’s Sixth District Court of Appeals, relying on the Ohio Supreme Court’s decision in *Anderson*,¹²⁶ affirmed the trial court’s decision and consequently deprived the plaintiff of any chance for redress.¹²⁷ The Appellate Court analyzed the impact of *Anderson* on the plaintiff’s negligence claim and reasoned that similar to the facts of *Anderson*, here, resuscitating the decedent against his wishes was not a compensable injury.¹²⁸ Specifically, the *Allore* court determined that in the instant case the plaintiff was seeking damages for the intubation of her decedent husband; thus, “the ‘harm’ that was proximately caused by [the] medical professional’s breach of duty in a prolongation of life case was the ‘benefit of life,’ a harm which courts have repeatedly refused to compensate.”¹²⁹ Accordingly, the court held that any

¹²²*Id.*

¹²³*Id.*

¹²⁴*Id.* at 563, 564. The court addressed the affidavit submitted by the decedent’s primary care pulmonologist Dr. Ali, which opined that Dr. Nahhas and Nurse Perry did in fact deviate from the relevant standard of care:

Here, [plaintiff] was required to offer specific, operative facts creating a genuine issue of material fact on the question of whether, by resuscitation of the decedent, Dr. Nahhas and Nurse Perry deviated from accepted standards of care for, respectively, physicians and nurses. Dr. Ali opined that Nurse Perry sought to circumvent his failure to order intubation and ventilation by ‘going behind his back’ to Dr. Nahhas and that this act is a deviation from accepted nursing standards. There are no facts in the record to support this inference. Instead, even in viewing the materials in support of and in opposition to the motion for summary judgment in a light most favorable to [plaintiff], reasonable minds could only conclude that no question of fact exists on the issue of whether Nurse Perry followed the admission orders of Dr. Ali by informing him of the emergency situation and, when he failed to respond, by calling Dr. Nahhas for treatment orders. Dr. Nahhas, who was not informed of the existence of the living will and durable power of attorney simply followed the standard of care employed in a situation where life saving measures are necessary. Accordingly, the trial court did not err in granting summary judgment on the issue of negligence as a matter of law and [plaintiff’s] first assignment of error is not well-taken.

Id. (internal citations omitted).

¹²⁵*Id.* at 563.

¹²⁶*Anderson v. St. Francis-St. George Hosp.*, 671 N.E.2d 225 (Ohio 1996).

¹²⁷*Allore*, 699 N.E.2d at 565.

¹²⁸*Id.* at 563.

¹²⁹*Id.* at 563 (citing *Anderson*, 671 N.E.2d at 225).

recovery is limited to damages resulting from an alleged battery.¹³⁰ Despite the fact that the plaintiff sought damages for unnecessary medical bills that resulted from unwanted medical care, because these damages flowed from the prolongation of her deceased husband's life, the court held they were not recoverable.¹³¹

2. *Anderson v. St. Francis Hospital*

In *Anderson v. St. Francis Hosp.*, the Ohio Supreme Court¹³² denied recovery to a plaintiff where the defendant hospital violated a patient's Do Not Resuscitate ("DNR") Order.¹³³ After the eighty-two year old patient, Mr. Winter, was admitted to a hospital for chest pain, he informed his doctor that if his heart failed, he did not wish to be resuscitated.¹³⁴ Accordingly, his doctor noted a DNR Order in his hospital chart.¹³⁵ Three days later, Mr. Winter suffered a heart attack, and a hospital nurse resuscitated him with defibrillation.¹³⁶ He later suffered a stroke that paralyzed his right side.¹³⁷

Mr. Winter brought suit against the hospital for injuries resulting from the stroke, alleging that the stroke he suffered would not have occurred but for the hospital's failure to obey the DNR order in his chart.¹³⁸ Initially, the trial court granted summary judgment in favor of the defendant-hospital, holding that under Ohio law plaintiff was unable to recover damages that were caused from the resuscitation, because this would be the equivalent of recognizing the prolongation of life as a compensable harm.¹³⁹ The plaintiff appealed, and Ohio's First District Court of Appeals reversed in part, holding that when applying the elements of negligence and battery, a plaintiff might be able to recover "damages for the reasonably foreseeable

¹³⁰*Id.*

¹³¹*Id.* at 565.

¹³²*Anderson*, 671 N.E.2d at 225.

¹³³*See generally id.* For a detailed, insightful discussion of *Anderson* illustrating that the court imposed its own moral judgment on the situation and ultimately, a decision that undermined a patient's choice to forego treatment, *see generally* S. Elizabeth Wilborn Malloy, *Beyond Misguided Paternalism: Resuscitating the Right to Refuse Medical Treatment*, 33 WAKE FOREST L. REV. 1035, 1060-69 (1998).

¹³⁴*Anderson*, 671 N.E.2d at 226. ("The plaintiff's reason for not wanting to be resuscitated stemmed from his fear of suffering the same fate as his wife, who had seriously deteriorated following an emergency resuscitation.")

¹³⁵*Id.*

¹³⁶Merriam-Webster's Medical Dictionary Online, available at <http://www.m-w.com/> (defining "defibrillation" as a process of applying an electric shock by an electronic device that restores the rhythm of a fibrillating heart).

¹³⁷*Anderson*, 671 N.E.2d at 226.

¹³⁸"Before his death, Winter initiated this action against the hospital for damages resulting from the hospital's failure to obey the "No Code Blue" order. After Winter died, appellee Keith W. Anderson, administrator of Winter's estate, amended the complaint to substitute himself as plaintiff." *Id.* at 225.

¹³⁹*Id.* at 226.

consequences of an unwanted resuscitation.”¹⁴⁰ The Ohio Supreme Court reviewed the case on a discretionary appeal.¹⁴¹

The Ohio Supreme Court, however, did not allow Mr. Anderson to recover under a negligence claim because of the difficulty that arises with establishing the causation and damages elements. The court stated that the causation element of a negligence cause of action could be satisfied in a case such as this only where the plaintiff presented evidence that the defibrillation itself caused or contributed to a resulting physical harm “in any way *other than by simply prolonging his life.*”¹⁴² The court found that Mr. Winter did not provide such evidence and barred recovery, stating that no issue better exhibits “the outer bounds of liability in the American civil justice system than this [one].”¹⁴³ The *Anderson* court reasoned that applying a “but for” causation test to a case such as this one would be overly inclusive and indicated that once the resuscitation is administered, there is no place for the “but for” test to stop.¹⁴⁴

Consequently, even if a plaintiff were able to prove the causation element in his prima facie case of negligence, the *Anderson* court still would not allow a plaintiff in Mr. Anderson’s position to recover damages because of the difficulty in ascertaining exactly what damages are caused from the harm of a prolonged life.¹⁴⁵ According to the court, the faulty premise of Mr. Winter’s negligence argument was that his damages flowed from the harm of being resuscitated and as a result, a prolonged life.¹⁴⁶ The court restated this point: “[t]here are some mistakes, indeed even

¹⁴⁰*Id.*

On remand, the trial court again granted summary judgment for the hospital. Applying standards based on negligence and battery, a different panel of the same court of appeals that had considered the first appeal reversed the judgment of the trial court, holding that Anderson may be entitled to damages for the reasonably foreseeable consequences of an unwanted resuscitation. The court remanded the cause for further proceedings in accordance with its reasoning.

Id.

¹⁴¹*Id.*

¹⁴²*Anderson*, 671 N.E.2d at 229.

¹⁴³*Id.* (stating that “[f]or purposes of a ‘wrongful living’ cause of action, the event or loss for which the plaintiff seeks damages is neither death nor life, but *the prolongation of life.* Thus, once it is established that but for the conduct of the medical professional, death would have resulted, the causation element of a ‘wrongful living’ claim is satisfied.”)

¹⁴⁴*Id.* at 228. (stating that if the “event would not have occurred ‘but for’ the defendant’s negligence, it still does not follow that there is liability, since other considerations remain to be discussed and may prevent liability. It should be quite obvious that, once events are set in motion, there is, in terms of causation alone, no place to stop.”)

¹⁴⁵*Id.*

¹⁴⁶*Id.* at 227. “American jurisprudence has developed at least three civil actions relating to the beginning and the extension of life: ‘wrongful life,’ ‘wrongful birth’ and ‘wrongful living’ . . . ‘wrongful living’ . . . is the basis for recovery in this case.” *Id.*

breaches of duty or technical assaults, that people make in this life that affect the lives of others for which there simply should be no monetary compensation."¹⁴⁷

The *Anderson* court narrowly construed the causation element by not allowing the act of resuscitation to be considered an injury capable of causing damage within the context of a negligence cause of action. Consequently, it prevented Mr. Winter from recovering for the type of damages that are caused from prolonging one's life.¹⁴⁸ As one writer has suggested, the *Anderson* court incorrectly implied that the plaintiff was seeking damages based on the wrongful extension of his life.¹⁴⁹ In actuality, the plaintiff was seeking damages for the harm of the "wrongful imposition of [medical] treatment."¹⁵⁰ The *Anderson* court incorrectly focused its analysis on the abstract question of whether death is ever preferable over life.¹⁵¹ Rather, the court should have framed its analysis in the context of protecting Mr. Winter's legally recognized right to refuse unwanted treatment.¹⁵²

When evaluating a plaintiff's claim in the context of a negligence cause of action, the plaintiff must prove his prima facie case consisting of the duty, breach, causation and damages elements.¹⁵³ A plaintiff must show that the health care providers deviated from the relevant standard of care by administering life-sustaining treatment to the patient. Moreover, a plaintiff must show that the damages he suffered were a direct and proximate cause of the act that prolonged his life, such as the act of defibrillation.¹⁵⁴ The *Allore* court refused to find an act of resuscitation to be a deviation from the relevant standard of care, even though the patient had a written living will specifically prohibiting the same. While the *Anderson* court, in

¹⁴⁷*Anderson*, 671 N.E.2d at 228.

¹⁴⁸*Id.*

In Winter's first appeal, the court of appeals properly concluded that there is no cause of action for 'wrongful living' and remanded for a determination of several issues related to traditional negligence and battery. In the second appeal, the court held that a patient may recover damages based upon the torts of negligence or battery *for all the foreseeable consequences of the therapy*, including the pain, suffering, and emotional distress beyond that which he normally would have suffered *had the therapy not been initiated*. The record clearly indicates that Winter would have died on May 30, 1988, without the defibrillation and, consequently, would not have suffered any subsequent medical conditions. Thus, the court of appeals' theory of recovery seems to be identical to the theory of recovery underlying a claim of 'wrongful living.' Both the law of the case and our holding here make this theory untenable, and damages, if any, must be based strictly on the theories of negligence or battery.

Id. (internal citation omitted).

¹⁴⁹Mark Strasser, A Jurisprudence in Disarray: On Battery, Wrongful Living, and the Right to Bodily Integrity, 36 SAN DIEGO L. REV. 997, 1023 (1999).

¹⁵⁰*See generally id.*

¹⁵¹*See generally Anderson*, 671 N.E.2d at 228.

¹⁵²*See generally Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 270 (1990).

¹⁵³*Anderson*, 671 N.E.2d at 227.

¹⁵⁴*Id.* ("[D]efendant is liable only for harms that are proximately caused by the tortious act").

accordance with *Cruzan*,¹⁵⁵ recognized that a cause of action arises from the violation of a patient's right to refuse life-sustaining medical treatment, the *Anderson* court held that to recover damages a plaintiff must present evidence that the resuscitative act itself caused the patient's resulting physical harm, rather than a general showing that the prolongation of the patient's life enabled the harm to ensue.¹⁵⁶

Because of the difficulties that plaintiffs face in seeking redress through a negligence action, such as proving the breach, causation, and damages elements, as evidenced by the *Anderson* and *Allore* decisions, negligence is an inadequate remedy to compensate a patient whose advance directive has been violated.

B. Battery

In a medical setting, when a physician treats a patient without his consent, the doctor has committed a battery¹⁵⁷ even if the treatment is actually medically beneficial.¹⁵⁸ Thus, in Ohio, a battery action will lie where medical treatment is administered after a patient expressly refuses consent.¹⁵⁹ A battery claim requires a plaintiff to show an "intentional, unconsented-to touching," causation and damages in the form of physical harm.¹⁶⁰ Where a battery is physically harmless, the plaintiff is only entitled to nominal damages.¹⁶¹ The common law battery cause of action offers no greater chance of success to a patient in Ohio whose advance directive or living will has been violated than does a negligence action, because the same complications that courts face with respect to the causation and damages elements in a negligence cause of action are present with a battery cause of action.

1. *Anderson v. St. Francis Hospital*

In *Anderson*, the Ohio Supreme Court held that where a plaintiff alleges a medical battery, the plaintiff may only recover for physical damages directly caused by the battery.¹⁶² Thus, where the battery was physically harmless, even if emotionally harmful, the plaintiff is entitled only to nominal damages.¹⁶³ While the *Anderson* court acknowledged that a patient has a "liberty interest in refusing

¹⁵⁵*Cruzan*, 497 U.S. at 261.

¹⁵⁶*Anderson*, 671 N.E.2d at 226, 229.

¹⁵⁷ *Estate of Leach v. Shapiro*, 469 N.E.2d 1047, 1048 (Ohio Ct. App. 1984).

¹⁵⁸ Edward J. Larson and Thomas A. Eaton, *The Limits of Advance Directives: A History and Assessment of the Patient Self-Determination Act*, 32 WAKE FOREST L. REV. 249 (1997).

¹⁵⁹ *Allore v. Flower Hosp.*, 699 N.E.2d 560, 564 (Ohio Ct. App. 1997).

¹⁶⁰ *Anderson*, 671 N.E.2d at 227.

¹⁶¹ *Id.* at 229.

¹⁶² *Id.*

¹⁶³ *Id.* (citing *Lacey v. Laird*, 139 N.E.2d 26 (Ohio 1956)) ("'Nominal damages' are those recoverable where a legal right is to be vindicated against an invasion thereof which has produced no actual loss of any kind, or where, from the nature of the case, some injury has been done, the extent of which the evidence fails to show. 'Nominal damages' are limited to some small or nominal amount in terms of money.'").

unwanted medical treatment,"¹⁶⁴ it failed to protect that interest by allowing recovery by a patient only where objective physical harm could be measured.¹⁶⁵ As a result, the court failed to acknowledge that violating a patient's right to refuse medical treatment could result in emotional or dignitary harm; neither of which can be objectively measured.

The *Anderson* court focused on the damages portion of the plaintiff's claim, as opposed to focusing on the most important issue: the right of the plaintiff to be free of the unwanted medical treatment of defibrillation. Instead, the *Anderson* court offered only a passing assertion that "unwanted life-saving treatment does not go undeterred" because the "consequences" of such treatment would include "damages arising from any battery inflicted on the patient, as well as appropriate licensing sanctions against the medical professionals."¹⁶⁶ The court did not, however, state how nominal damages, which are the only damages that the court would allow for emotional or dignitary harm, would deter future incidents of administering unwanted treatment.¹⁶⁷

In requiring objectively measurable physical harm in order for a patient to recover damages under a battery cause of action, the Ohio Supreme Court undermined the right to refuse medical treatment. This right was recognized by the United States Supreme Court in *Cruzan*,¹⁶⁸ which held that a competent person has a liberty interest under the Due Process Clause in refusing unwanted medical treatment.¹⁶⁹ While the *Anderson* court briefly acknowledged this right as recognized within *Cruzan*,¹⁷⁰ it did not state how it expected this right to be protected without affording a remedy to aggrieved patients.¹⁷¹ Namely, the *Anderson* court did not justify why it would not allow the plaintiff to recover for an emotional or dignitary harm caused where a health care provider intentionally disregarded a patient's right to refuse medical treatment; a right that the *Cruzan* court held was deeply embedded in American jurisprudence.¹⁷² As stated by the United States Supreme Court: "[i]t is

¹⁶⁴*Anderson*, 671 N.E.2d at 227.

¹⁶⁵*Id.* at 229.

¹⁶⁶*Id.*

¹⁶⁷*See generally id.*

¹⁶⁸*Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990).

¹⁶⁹*Id.* at 278-80 (citing *cf., e.g., Jacobson v. Mass.*, 197 U.S. 11, 24-30 (1905)) (The Fourteenth Amendment provides that no State shall "deprive any person of life, liberty, or property, without due process of law." The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions. In *Jacobson v. Massachusetts*, for instance, the Court balanced an individual's liberty interest in declining an unwanted smallpox vaccine against the State's interest in preventing disease.") (citation omitted).

¹⁷⁰*Anderson*, 671 N.E.2d at 227.

¹⁷¹*See generally id.*

¹⁷²*Cruzan*, 497 U.S. at 278-80 (basing this determination on its previous declaration that "[n]o right is held more sacred . . . than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law").

a settled and invariable principle, that every right, when withheld, must have a remedy, and every injury its proper redress.”¹⁷³ Accordingly, if the Ohio Supreme Court recognizes the right to refuse treatment, it must afford a remedy where the patient’s right has been withheld.

2. *Allore v. Flower Hospital*

The *Allore* court followed the reasoning in *Anderson* and denied the plaintiff redress for the battery cause of action.¹⁷⁴ While the court acknowledged that where a health care provider treats a patient without obtaining the patient’s consent, even in an emergency situation, the health care provider has committed a battery, it denied the plaintiff recovery because the specific damages that plaintiff sought were not related to the battery itself.¹⁷⁵

The reason offered by the *Allore* court for denying the plaintiff recovery under a battery theory was that the plaintiff had claimed damages wholly unrelated to the battery itself: damages based on unwanted medical care, unnecessary medical bills, unnecessary pain and suffering, and emotional distress suffered by her decedent-husband.¹⁷⁶ The plaintiff “neither requested damages arising from the act of intubation/ventilation itself nor for nominal damages for the battery.”¹⁷⁷

By allowing only nominal damages under a battery cause of action where the injury suffered was pain, suffering, and emotional distress, both the *Anderson* and *Allore* courts failed to protect the patients’ rights to refuse medical treatment through the use of written advance directives in Ohio.¹⁷⁸ Thus, under current Ohio case law, a battery action is an inadequate remedy to compensate a patient whose advance directive has been violated.

C. *Intentional Infliction of Emotional Distress and Perkins*

In Ohio, an intentional infliction of emotional distress action is also an inadequate remedy to compensate a patient whose written health care directive has been violated. In order for a plaintiff to recover, she must establish the provider’s intent to cause serious emotional distress, extreme and outrageous conduct that exceeds “all possible bounds of decency,”¹⁷⁹ and causation.¹⁸⁰ Insensitive or even

¹⁷³Marbury v. Madison, 5 U.S. 137, 147 (1805).

¹⁷⁴Allore v. Flower Hosp., 699 N.E.2d 560, 564-65 (Ohio Ct. App. 1997).

¹⁷⁵Estate of Leach v. Shapiro, 469 N.E.2d 1047, 1052 (Ohio Ct. App. 1984) (citing Wells v. Van Nort, 125 N.E. 910 (Ohio 1919); *Allore*, 699 N.E.2d at 564 (“In a medical setting, when a physician treats a person without consent, the doctor has committed a battery.”) (citing *Leach II*, 469 N.E.2d at 1051). “In contrast, a physician’s acts are lawful when the patient expressly consents prior to medical treatment.” *Id.* “Medical treatment also will be lawful under the doctrine of implied consent when a medical emergency requires immediate action to preserve the health or life of the patient.” *Id.* at 1052 (citing *Wells*, 125 N.E.2d 910). “A potential patient may, however, expressly refuse treatment.” *Leach II*, 469 N.E.2d at 1053. “If so, even in an emergency, any medical treatment is a battery.” *Id.* at 1052.

¹⁷⁶*Allore*, 699 N.E.2d at 565.

¹⁷⁷*Id.*

¹⁷⁸*Anderson v. St. Francis – St. George Hosp.*, 671 N.E.2d 225, 229 (Ohio 1996).

¹⁷⁹*Roelen v. Akron Beacon Journal*, 199 F. Supp. 2d 685 (N.D. Ohio 2002).

cruel conduct exhibited by a non-complying provider may not allow a plaintiff to recover damages because such conduct may result in subjective emotional damage that cannot be objectively measured.¹⁸¹

In the case of *Perkins v. Lavin*,¹⁸² Mrs. Perkins, the plaintiff and a Jehovah's Witness,¹⁸³ executed a written directive in the form of a release, specifically stating that she did not wish to receive any blood products or transfusions during a surgical procedure.¹⁸⁴ The written release absolved both her provider and the hospital from the imposition of liability resulting from injuries incurred as a result of her not receiving necessary blood products during surgery.¹⁸⁵

Due to surgical complications, Mrs. Perkins' blood count dropped and her provider administered a blood transfusion as "a life-saving measure."¹⁸⁶ Mrs. Perkins brought suit against her provider for battery and intentional infliction of emotional distress. The *Perkins* court examined the physician's behavior in light of the "average member of the community"¹⁸⁷ and found the provider's conduct to be

¹⁸⁰*Fitzgerald v. Roadway Express, Inc.*, 262 F. Supp. 2d 839, 840 (N.D. Ohio 2003) (describing "[e]xtreme and outrageous" conduct as occurring in cases "in which the recitation of the facts to an average member of the community would arouse his resentment against the actor, and lead him to exclaim, 'Outrageous!'").

¹⁸¹*Roelen*, 199 F. Supp. 2d at 696.

¹⁸²*Perkins v. Lavin*, 648 N.E.2d 840 (Ohio Ct. App. 1994).

¹⁸³Jehovah's Witnesses hold as a tenant to their faith, that the Bible forbids blood transfusions. The decision not to receive blood products is a "nonnegotiable religious stand that Jehovah's Witnesses take. They highly value life, and they seek good medical care. But they are determined not to violate God's standard, which has been consistent: *Those who respect life as a gift from the Creator do not try to sustain life by taking in blood.*" Information regarding Jehovah's Witnesses' faith and doctrines can be found at the religion's official website: <http://www.watchtower.org/>. The website contains faith-based reasons for refusing blood products, as well as medical treatment alternatives to blood products. Jehovah's Witnesses cite several passages from the Bible that allegedly forbid followers from receiving blood products, including: Isaiah 48:17; Genesis 9:3-6; Leviticus 7:26; 17:10, 11 (Tanakh); Leviticus 11:4-8; 13; 17:13, 14; Deuteronomy 23:12, 13; 15:23; Ezekiel 33:25; 1 Samuel 14:31-35; Acts 15:1-21.

¹⁸⁴*Perkins*, 648 N.E.2d at 840.

¹⁸⁵*Id.*

¹⁸⁶*Id.*

¹⁸⁷*Id.* at 842.

reasonable.¹⁸⁸ Thus, the court granted the provider summary judgment on the intentional infliction of emotional distress claim.¹⁸⁹

To establish a prima facie case for intentional infliction of emotional distress, the plaintiff must show that the conduct element is extreme and outrageous, and thus shocking to an average member of the community. Consequently, the court did not analyze the conduct in terms of the subjective view of the plaintiff. Instead, the court focused on the conduct of the provider as viewed by the average member of the community. The approach deemphasizes the very personal right to refuse medical treatment whether or not the average member of the community would chose to do so.

In Mrs. Perkins' case, the decision to refuse a blood transfusion was a very solemn and personal choice. Her reasons for doing so should not have to be validated by a member of the "average" community. Rather, her choice, as expressed in a written release form, should have been strictly respected and honored. Because the conduct element of this cause of action is viewed in light of the average member of the community, as opposed to the personal reasons a patient may have for refusing medical treatment, the intentional infliction of emotional distress cause of action does not afford a remedy to a patient whose advance directive has been violated.

D. Conclusion of Ohio's Insufficient Common Law Causes of Action

Ohio's case law demonstrates that the common law causes of action of negligence, battery, and intentional infliction of emotional distress are useless remedies to compensate a patient whose right to refuse life-sustaining medical treatment through the use of an advance directive has been violated. Negligence has proven be an insufficient cause of action because of the difficulties a plaintiff will face in establishing the breach, duty and causation elements in her prima facie case. The *Allore* court refused to find resuscitation to be a deviation from the relevant standard of care, focusing on the relevant standard of conduct of a "reasonable specialist" rather than focusing on the health care provider's blatant disregard of a patient's right to refuse medical treatment. The *Anderson* court refused to allow a plaintiff to recover where the plaintiff suffered the harm of diminished health and lifestyle resulting from a stroke that occurred following a resuscitation that he expressly prohibited in the form of a DNR order in his hospital chart. Rather than focusing on the administration of a medical treatment that was expressly forbidden by the patient, the *Anderson* court analogized the patient's claim to a wrongful living cause of action, a cause of action not recognized or compensable under Ohio law. The *Anderson* court reasoned that ultimately the elements of causation and damages

¹⁸⁸*Id.* (holding that "[d]efendant's conduct that plaintiff claimed was an intentional infliction of emotional distress on her was the provision of a blood transfusion that saved her life and provided her an opportunity to raise the baby girl to which she had given birth just days before. Rather than an average member of the community exclaiming that defendant acted outrageously by providing that transfusion, such a person would view it as outrageous if defendant had not provided it. Accordingly, there was no genuine issue of material fact and defendant was entitled to judgment as a matter of law dismissing plaintiff's claim for intentional infliction of emotional distress. That part of plaintiff's second assignment of error related to her intentional infliction of emotional distress claim is overruled").

¹⁸⁹*Id.*

that resulted from resuscitating and prolonging one's life are non-compensable because the court cannot place a "price tag" on the value of one's life.¹⁹⁰

Both *Allore* and *Anderson* show that battery is also an inadequate remedy, because of the same issues discussed by the Ohio Supreme Court in *Anderson* regarding the causation and damages elements in a negligence action also plague the battery cause of action. Finally, *Perkins* illustrates that intentional infliction of emotional distress is an inefficient remedy because, similar to *Allore* and *Anderson*, the court focused on the conduct of the health care provider as viewed by the average member of the community, rather than the violation of the patient's deeply personal right to refuse medical treatment.

While analysis of the foregoing cases establishes that Ohio courts do not afford a remedy where the right to refuse medical treatment through the use of a written directive has been denied, the Ohio Legislature, through the adoption of a civil and criminal statutory immunity provision within the Modified Rights of the Terminally Ill Act, has also effectively stripped aggrieved patients of the right to a remedy. Thus, it is up to the legislature, as the elected representative body of Ohio patients, to take action and codify, protect and enforce the Ohio patient's right to refuse medical treatment through the use of a written advance directive.

V. PROPOSAL TO PROTECT THE OHIO PATIENT'S RIGHT TO AUTONOMY

The Modified Uniform Rights of the Terminally Ill Act establishes guidelines for executing written advance directives. It does not, however, establish any protection for a patient's right to refuse medical treatment through the use of advance directives. Conversely, the Act codifies civil and criminal immunity for health care providers who do not abide by a patient's advance directive.¹⁹¹ As a result, health care providers in Ohio are not legally obligated to strictly comply with a patient's advance directive or living will. The Ohio Legislature needs to take immediate action to protect a patient's right to refuse medical treatment by codifying a patient's right to seek a remedy when a provider disregards a written advance directive. Furthermore, by repealing civil and criminal immunity and imposing monetary sanctions against non-complying providers and institutions in the form of fines, the legislature can deter provider non-compliance. Finally, educating state funded institutions about the benefits of using a national Living Will Registry will encourage compliance because of the relative ease of accessing directives through the Registry.

A. Repeal Civil Statutory Immunity and Codify a Patient's Right to Seek a Remedy

The Act's civil and criminal immunity provision essentially protects health care providers who fail to respect an individual's right to refuse treatment as expressed in a written advance directive. This undermines a principle central to the common law doctrine of informed consent: that every adult of sound mind has the right to refuse medical treatment.¹⁹² By granting civil and criminal statutory immunity, a patient is effectively denied the right to recover damages from a provider who ignores a

¹⁹⁰*Anderson v. St. Francis – St. George Hosp.*, 671 N.E.2d 225, 228 (Ohio 1996).

¹⁹¹OHIO REV. CODE ANN. § 2133.02 (D) (1) (West 2006).

¹⁹²*Schloendorff v. Society of N.Y. Hospital*, 105 N.E. 92, 93 (N.Y. 1914).

patient's advance directive.¹⁹³ The right to refuse medical treatment has been recognized by the United States Supreme Court in *Cruzan*. The Ohio Legislature recognized this right by codifying the Modified Uniform Rights of the Terminally Ill Act. As a result, it seems that "[p]hysicians should not be able to make a legislatively and judicially conferred right meaningless."¹⁹⁴ Thus, if a patient's right to refuse unwanted medical treatment is to have any significance, the Ohio Legislature must provide a remedy for intentional or negligent violations of this right.¹⁹⁵

The grant of civil immunity under Ohio law invalidates a patient's right to bodily autonomy¹⁹⁶ and allows health care providers too much discretion to "trump the constitutional rights of patients."¹⁹⁷ In order to properly protect a patient's right to refuse medical treatment, the Ohio Legislature needs to repeal civil immunity for health care providers who fail to comply with a patient's written declaration refusing medical treatment.¹⁹⁸ By repealing civil immunity, health care providers could be held liable for medical malpractice, and both health care providers and institutions would have a financial incentive to educate and train health care providers regarding the legal consequences of non-compliance.

Because the traditional common law causes of action of negligence, battery, and intentional infliction of emotional distress do not currently afford a patient an adequate remedy, codification of the right to seek a remedy, such as battery, negligence or intentional infliction of emotional distress for advance directive violations is the most practical solution. Codification of a remedy would logically fit within Ohio's Modified Rights of the Terminally Ill Act¹⁹⁹ or Ohio's Durable Powers of Attorney for Health Care statute²⁰⁰ because these statutes currently govern the use and execution of written declarations, such as advance directives, living wills, and powers of attorney, to consent to or refuse medical treatment on behalf of a patient. Codification of a remedy would provide a uniform standard for health care providers and institutions to follow and would guide such institutions in choosing the most effective manner and means of education for providers and patients alike. Ohio could look to the state of Tennessee as a starting point to find a statute that protects a patient's right to refuse treatment by exposing health care providers to civil liability

¹⁹³OHIO REV. CODE ANN. § 2133.02 (D) (1) (West 2006).

¹⁹⁴S. Elizabeth Wilborn, *The Right to Refuse Medical Treatment Where There is a Right, There Ought to be a Remedy*, 25 N. KY. L. REV. 649, 672 (1998).

¹⁹⁵*See generally id.* *See also* Mary A. Bobinski, *Autonomy and Privacy: Protecting Patients from Their Physicians*, 55 U. PITT. L. REV. 291 (1994).

¹⁹⁶Ohio is not alone in granting immunity to health care providers and institutions. *See generally* ALASKA STAT. § 13.52.060 (e) (2004); ARIZ. REV. STAT. § 36-3205 (1992); GA. CODE ANN. § 31-32-8 (b) (1992); IOWA CODE § 144A.9 (2002) and § 144B.9 (2004); WASH. REV. CODE § 70.122.060 (3) (1992).

¹⁹⁷Maggie J. Randall Robb, *Living Wills: The Right to Refuse Life Sustaining Treatment – A Right Without a Remedy?*, 23 U. DAYTON L. REV. 169, 185 (1997).

¹⁹⁸OHIO REV. CODE ANN. § 2133.02 (D) (West 2006).

¹⁹⁹OHIO REV. CODE ANN. § 2133.01-15 (West 2006).

²⁰⁰OHIO REV. CODE ANN. § 1337.11-17 (West 2006).

for refusing to comply in “good faith” with a patient’s advance directive.²⁰¹ By repealing civil immunity and codifying a patient’s right to seek a remedy under a common law cause of action, the legislature would effectively protect a patient’s fundamental right to refuse unwanted medical treatment.

B. Repeal Criminal Statutory Immunity

In conjunction with repealing civil immunity, the Ohio legislature should repeal statutory immunity²⁰² to the extent that would allow the state to impose criminal monetary sanctions on health care providers and their employer-institutions as a result of violating a patient’s written declaration. While criminal sanctions will not compensate aggrieved patients or their loved ones, imposing criminal sanctions in the form of monetary fines would serve as an additional financial incentive for providers to abide by a patient’s written declaration.

In addition, the legislature should require publication of the names of providers and institutions criminally sanctioned for violating advance directives. Publishing the identities of non-complying health care providers would encourage compliance because providers will be motivated to safeguard their professional reputation within the medical community. Non-complying providers could be identified by having their names published on a health care institution accrediting agency’s website.²⁰³ Furthermore, publication on an accreditation website would be easily accessible to the general public and would allow patients who have executed advance directives to make informed decisions regarding where they choose to receive care.²⁰⁴ Health care providers and institutions may feel a sense of embarrassment if the public is made aware, through publication, of the imposition of criminal fines on them.

²⁰¹TENN. CODE ANN. § 32-11-108 (a) (2006) (stating that “[a]ny health care provider who fails to make good faith reasonable efforts to comply with the preceding procedure as prescribed by the attending physician shall be civilly liable and subject to professional disciplinary action, including revocation or suspension of license.”). *See also* W. VA. CODE § 16-30-22 (2005) (“A health care provider or a health care facility is subject to review and disciplinary action by the appropriate licensing board for failing to act in accordance with a principal’s directives in a living will . . . [p]rovided, that the provider or facility had actual knowledge of the directive.”).

²⁰²OHIO REV. CODE ANN. § 2133.02 (D) (West 2006).

²⁰³For example, the Joint Commission on Accreditation of Health Care Organizations (“JCAHO”) is an independent, non-profit organization that is governed by a board of physicians, nurses, and consumers. JCAHO sets the standards by which health care quality is measured in the United States, by evaluating the quality and safety of care for more than 15,000 health care organizations. JCAHO conducts extensive on-site reviews of health care institutions every three years. JCAHO accredited institutions and their inspection results are posted on JCAHO’s official website, <http://www.jcaho.org/index.htm>. JCAHO’s 2005 Assisted Living Standards, http://www.jcaho.org/htba/assisted_living/05_al_xwalk.pdf. (recognizing that an assisted living patient-resident has a “right to formulate advance directive” and requires the providers in the assisted living community to determine “whether a resident has advance directives or designated a surrogate decision maker for health care decisions when the resident is admitted.”).

²⁰⁴*See generally* Joint Commission Home Page, <http://www.jcaho.org/index.htm> (last visited Oct. 18, 2006). For example, JCAHO has a “Quality Check” search engine available on its website that allows a person to find JCAHO accredited institutions within a geographical area for the type of care sought.

C. Recognize a National Advance Directive²⁰⁵

In combination with repealing immunity and codifying a patient's right to seek a remedy, Ohio should promote and adopt a "national" advance directive form.²⁰⁶ More people might be encouraged to execute advance directives by simplifying governing laws and achieving a uniformed system for advance care planning.²⁰⁷ The implementation of a single advance directive that would be recognized in all fifty states is one way to achieve this, and may simplify the process of executing an advance directive by facilitating the creation of a straightforward, standard form that can be easily read and understood by laymen. This alone may encourage more Ohioans to execute advance directives, because the Ohio disclosure provisions that currently accompany an advance directive total over 1600 words.²⁰⁸

In conjunction with codifying an adequate remedy and repealing civil and criminal immunity, implementing a national form will ensure that out-of-state persons' advance directives are complied with throughout Ohio. While Ohio statutory law recognizes an out-of-state advance directive as valid, so long as it was executed in compliance with the legal requirements of the respective state in which it was executed, someone within the health care setting would require the knowledge needed to assess the legality of the out-of-state form.²⁰⁹ In an urgent medical situation, where time is of the essence, a health care provider may not have the luxury of the time it may take to contact the hospital's legal department to determine if the out-of-state advance directive is legally compliant with Ohio's law; this could increase the risk of non-compliance with an out-of-state form in the event that the provider needs to make an immediate decision regarding the implementation of life sustaining treatment.

Ohio's current statutory provision validating out-of-state forms is of little to no use to health care providers during a medical emergency when treatment decisions need to be made instantaneously.²¹⁰ As one writer noted, "the ever-increasing mobility of society as well as the desires of an aging baby boomer population may fuel an increasing demand for simplicity and flexibility in the legal tools we have created for health care advance planning."²¹¹ Accordingly, the implementation of a national form would facilitate compliance from health providers by reducing anxiety regarding legal requirements of execution for out-of-state advance directives.

²⁰⁵Charles P. Sabatino, Esq., *National Advance Directives: One Attempt to Scale the Barriers*, 1-SPG NAELA J. 131 (2005).

²⁰⁶*See generally id.* (for a detailed analysis of the use of one form as a national advance directive, as well as the principal barriers to universal recognition in the fifty states).

²⁰⁷*See Sabatino, supra* note 205, at 132.

²⁰⁸OHIO REV. CODE ANN. § 1337.17 (West 2006).

²⁰⁹OHIO REV. CODE ANN. § 2133.14 (West 2006); *see Sabatino, supra* note 205, at 134.

²¹⁰§ 2133.14.

²¹¹*See Sabatino, supra* note 205, at 154.

D. Encourage Awareness of a National Living Will Directory

Repealing statutory civil and criminal immunity for non-complying providers, codifying the right for patients to seek a remedy and adopting a national advance directive form will encourage providers to comply with advance directives. However, many providers will still be faced with administrative limitations that will prevent them from accessing advance directives when they are needed. Many patients execute advance directives long before they are needed; thus, when a patient is later admitted to a hospital for treatment, the hospital staff may not be aware that the patient has previously executed the advance directive if the patient is unable to communicate.²¹² Additionally, in cases where a provider becomes aware of a previously executed advance directive, if the date of execution appears too old, a provider may question the accuracy of the document as a current reflection of the patient's true intentions regarding treatment decisions.

In order to encourage increased provider access to patient advance directives, the Ohio Legislature should codify a requirement that institutions receiving state funding provide education to hospital employees regarding the existence of the United States Living Will Registry ("Registry").²¹³ The Registry is an electronic storage system for advance directives that eliminates the need for health care institutions to maintain their own storage or retrieval systems.²¹⁴ The Registry is accessible by telephone or

²¹²Debra M. Bryan, *It's My Body and I'll Die if I Want To: A Plan for Keeping Personal Autonomy From Spinning Out of Control*, 8 J. MED. & L. 45, 61 (2004) (stating that "[t]here are additional programs in place to provide notice of advance directives. Many hospitals and medical facilities have recording procedures in place, but a survey of these show great disparity in consistency and reliability. Implementation of such record-keeping may be cumbersome and difficult, especially for facilities whose personnel is already overburdened in just caring for patients. In these situations, the United States Living Will Registry provides a uniform and consistent way in which to store and access records. In addition to the free access capability, medical facilities can join the registry's membership program. Although the facility would pay a yearly fee, membership provides them with access to an automated system. Through this system, medical personnel can obtain emergency contact or advance directive information in a matter of minutes. Non-member facilities can access the registry free of charge, but cannot access the automated version. In many cases, a medical facility's membership would be offset by the amount of time, effort and expense it takes to administer their own recordation procedure for advance directives, and would assure compliance and consistency that may be otherwise questionable.").

²¹³The Ohio Legislature could look to The Patient Self Determination Act ("PSDA") for guidance. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4206, 4751, 104 Stat. 1388, 1388-115 to -117, 1388-204 to -206 (codified throughout 42 U.S.C.). The PSDA is a federal law that requires institutions receiving federal Medicare or Medicaid funding to inform patients of their rights to execute advance directives. For an analysis of the impact and success of the PSDA, see generally Edward J. Larson and Thomas A. Eaton, *The Limits of Advance Directives: A History and Assessment of the Patient Self-Determination Act*, 32 WAKE FOREST L. REV. 249 (1997). See also Thaddeus Mason Pope, *The Maladaptation of Miranda to Advance Directives: A Critique of the Implementation of the Patient Self-Determination Act*, 9 HEALTH MATRIX 139 (1999).

²¹⁴The United States Living Will Registry, <http://www.uslivingwillregistry.com> (Oct. 18, 2006) ("Certified Orthopedic Surgeon, Dr. Barmakian, has witnessed the ordeal of patients' families as they confront the painful, guilt-ridden decisions of life support and medical treatment. He has also felt the frustration of doctors who don't have access to patients' wishes.

internet twenty-four hours a day.²¹⁵ Health care providers can request and receive an advance directive from the Registry instantly.²¹⁶ The Registry is self-funded and is accessible to medical facilities free of charge.²¹⁷

Health care providers can confidently rely on the accuracy of advance directives maintained within the Registry because each registrant is contacted yearly to verify that their advance directive wishes have not changed.²¹⁸ Once an individual (“declarant”) registers an advance directive with the Registry, the advance directive, along with emergency contact information, is stored for the life of the declarant.²¹⁹ Additionally, after registering an advance directive, the declarant is provided with labels to attach to a driver’s license or health care insurance card which serves to notify medical facilities that the declarant does in fact have a registered advance directive on file, as well as a “wallet card”²²⁰ which provides instructions on how to access the declarant’s advance directive.²²¹

In addition to providing a uniform system of storing and retrieving advance directives, the Registry would likely reduce the administrative costs that hospitals currently endure to administer their own storage and retrieval systems for advance directives and would increase provider compliance by making advance directives easily accessible.²²² By educating hospital staff about the benefits conferred on health care providers utilizing the Registry, such as reduced administrative burdens,²²³ health care institutions and providers can collectively determine the most

It was in 1996 that Dr. Barmakian first recognized the need for a registry service that not only recorded patients' advance directives, but also made it easier for health care facilities to obtain the information. Dr. Barmakian felt it was critical to establish a system which provides medical personnel and patient’s families with advance directives whenever and wherever they are needed while maintaining the patient's privacy and confidentiality. United States Living Will Registry fulfills these criteria, providing easy, 24-hour access to patients’ wishes.”)

²¹⁵*Id.*

²¹⁶*Id.*

²¹⁷*Id.*

²¹⁸*Id.*

²¹⁹*Id.*

²²⁰ A sample “wallet card” can be viewed at: <http://www.uslivingwillregistry.com/walletcard.shtm>.

²²¹*Id.*

²²²*See* Bryan, *supra* note 212.

²²³*See generally* Health Care Providers Benefits *available at* <http://www.uslivingwillregistry.com> (“People are commonly told to give copies of their advance directive to their family members . . . [b]ut when the time comes to find the document, it is usually not available, or is so old that some may doubt its validity. By definition, these documents are prepared well in advance of when they will be needed, and they are commonly put away for ‘safe keeping’ . . . mak[ing] them difficult to find.”) (discussing that administrative issues such as storage and retrieval of advance directives has proved to be a burden on health care providers, as well as other legal concerns such as: determining which advance directive in a patient’s file is the most recent version; not having sufficient time to locate an advance directive when a patient is re-admitted to a hospital; not knowing how to properly store an

efficient manner in which to incorporate use of the Registry into their own standard operating procedures.

E. Conclusion of Proposals to Protect the Ohio Patient's Right to Autonomy

The Modified Uniform Rights of the Terminally Ill Act, in its current state, protects health care providers who do not comply with a patient's advance directive. The Act's grant of civil and criminal statutory immunity effectively denies a patient the right to recover damages from a provider who ignores a patient's advance directive.²²⁴ In order to protect a patient's right to refuse medical treatment, the Ohio Legislature needs to repeal civil and criminal immunity. In addition, the legislature should codify the right of a patient to seek a remedy, because the common law causes of action of battery, negligence, and intentional infliction of emotional distress do not afford an adequate remedy to aggrieved patients. Additionally, implementation of a national advance directive form would facilitate compliance from providers by reducing insecurity regarding legal requirements of execution. Finally, encouraging awareness of the United States Living Will Registry will increase access to advance directives and allow them to be obtained instantly.

VI. CONCLUSION

Patients have the right to refuse medical treatment. Presently, competent patients orally refuse medical treatment everyday. Because competence is required to exercise the right to refuse certain medical treatment, many people choose to express their wishes regarding future medical care in the form of a written advance directive. An advance directive sets out, in writing, a person's desires regarding medical treatment in the event that the person cannot orally do so as a result of a mentally debilitating disease or injury. When a person becomes incompetent, he cannot orally consent or refuse to consent to certain medical treatments. Executing a written advance directive gives a person the option to preclude certain types of future medical treatment in the event that he becomes unable to orally consent to or refuse medical treatment.

Modern advancements in medical treatments have increased the need for patients to execute advance directives while planning for end-of-life decisions.²²⁵ Advance directives are a viable legal option available to patients who choose to protect their right to refuse medical treatment in the event that their mental competency is lost to injury or disease.²²⁶ In order to protect a patient's right to refuse medical treatment, the legislature needs to repeal the statutory immunity granted to health care providers who violate a patient's written advance directive, impose sanctions in the form of

advance directive when a patient's file is converted to microfiche or an electronic storage database).

²²⁴OHIO REV. CODE ANN. § 2133.02 (D) (1) (West 2006).

²²⁵See generally RONALD E. CRANFORD, MODERN TECHNOLOGY AND THE CARE OF THE DYING, IN BIRTH TO DEATH: SCIENCE AND BIOETHICS 191-97 (David C. Thomasma & Thomasine Kushner eds., Cambridge University Press 1996); see also *Developments in the Law -- Medical Technology and the Law*, 103 HARV. L. REV. 1519, 1522 (1990).

²²⁶See generally *id.* (for an analysis regarding "the relationship between law and medicine in . . . the major areas in which advances in medical knowledge have created legal, ethical, political, and economic dilemmas beyond those encountered in 'traditional' medicine.").

monetary fines against non-complying providers and institutions, and codify a patient's right to seek a remedy. Additionally, recognition of a national advance directive form would encourage greater provider compliance by providing an easily recognizable form with standard execution requirements. Lastly, requiring state funded institutions to educate hospital staff about the benefits of utilizing the United States Living Will Registry will facilitate easier access to patient advance directives by providers.

Over the past twenty-six years, Ohio law has not increased the protection of a patient's right to refuse medical treatment through the use of a written declaration. In 1980, at the time of Edna Leach's death, patient consent had to be expressed orally either by the competent patient who was able to communicate or through an incompetent patient's family members. Although the Modified Uniform Rights of the Terminally Ill Act was codified in 1991 and grants civil and criminal statutory immunity to providers who do not comply with an advance directive, it is virtually worthless in terms of the protection it provides over a patient's right to refuse future medical treatment. Thus, a patient executing a written advance directive today will enjoy no greater assurance that her wishes regarding treatment decisions will be complied with any more than Edna Leach's wishes were complied with as expressed through her family members twenty-six years ago.

As medical technology continues to rapidly accelerate and the law continues to lag behind, the consequence will be the evisceration of fundamental rights, such as the right to bodily integrity and the right to be free of unwanted contact in a medical setting. The legislature owes a duty to its citizens to protect patients' rights to refuse treatment at the end of life. Until the Ohio Legislature increases protection of a patient's right to refuse medical treatment through an advance directive, the right to refuse medical treatment in Ohio is a right without a remedy.²²⁷

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²²⁷See generally Robb, *supra* note 197.

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