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Nutrition and Hydration under Ohio's DPAH: Judicial Misconstruction Threatens the Right to Choose Death with Dignity

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Years ago, life and death were as distinguishable as black and white. Simple definitions sufficed: Death was pronounced when the heart and lungs ceased to function.\(^1\) As medical technology became more complex in its ability to save lives, so did the definition of life itself.

In 1968 the Harvard Ad Hoc Committee published guidelines for determining whether someone had died. They suggested that a dead person would: 1) be unresponsive to and unaware of external stimuli; 2) have no spontaneous respiration; 3) lack reflexes of any sort; and 4) have a flat electroencephalogram, or EEG.\(^2\) Even this definition became outdated. In 1981 the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research suggested the adoption of a definition of death formulated by the American Bar Association, the American Medical Association, and others.\(^3\) This definition states that a dead person is one who has either sustained (1) "irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem."\(^4\)

Ohio's definition of death adopts the criterion suggested by the President's Commission.\(^5\) The difficulty with this definition, however, is that

\(^1\) Leach v. Akron Gen. Medical Center, 68 Ohio Misc. 1, 6, 426 N.E.2d 809, 812 (1980), (citing Evans v. Halterman, 31 Ohio App. 175, 165 N.E. 869 (1928)).
\(^3\) PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 9 (1983) [hereinafter DECIDING TO FOREGO].
\(^4\) Id. at 9-10, 10 n. 7.
\(^5\) OHIO REV. CODE ANN. § 2108.30 (Baldwin 1987) reads in pertinent part:

An individual is dead if he has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation.
it does not account for people like Karen Quinlan and Nancy Cruzan who, although not dead by any definition, are on the blurry boundary between life and death. Unaccounted for in this definition of death are those who suffer such severe brain damage that they are irreversibly doomed to a non-cognitive life, artificially sustained by mechanical support of their vital biological functions.

In the past, those who are now resuscitated with modern technological procedures such as electrical impulses to the heart, artificial respirators, and nutrition and hydration apparatus, would have simply died. While medical technological advances in aggressive life support systems should be heralded as a tribute to man's triumph over death (particularly in cases where the individual can return to a cognitive lifestyle), these advances should not force each person to hang on to his life indefinitely, just because technology now permits him to do so. Many feel alienated and frightened by apparatus that simply prolongs their dying process.

By 1977 greater than 70% of the nation's population died in institutions such as hospitals, nursing homes, or other long-term care institutions. This number had been increasing over the decades and is now estimated to be over 80%. Many never regain cognition. Recent count indicates that 10,000 Americans now remain, for whatever reason, in an incurable and persistent vegetative condition, trapped in a state of life made possible by aggressive life support systems.

A dilemma exists: How do these non-cognitive individuals fit into the legal definitions of life and death? What rights do they, their guardians,
or others have in decisions concerning artificial life support, including nutrition and hydration? To resolve the dilemma, a policy based on sound reasoning needs to be established in Ohio to determine if and when the termination of life support, including nutrition and hydration, can occur.  

Recently, Ohio has had two chances to formulate a policy concerning the withdrawal or refusal of artificial means of administering food and water. First, in September, 1989, the Ohio legislature enacted a statute, the Durable Power of Attorney for Health, which permits a competent Ohio adult to grant the power to another designated competent adult to make certain health care decisions for them in the event of their later incompetency. This statute details when an attorney in fact may refuse or withdraw nutrition and hydration from the incompetent who had completed the DPAH document. The statute also indicates what common-law rights remain in a guardian who may or may not be the attorney in fact, independent of the additional powers granted by the statute.

Second, in August, 1989, the Montgomery County Court of Appeals in *Couture v. Couture,* interpreted the Durable Power of Attorney for Health statute (DPAH) as forbidding the withdrawal or refusal of artificial means of nutrition and hydration where death was not imminent, notwithstanding the consent of the individual. For that reason, the *Couture* court refused to grant permission to remove the nasogastric tubing from a young man who had lapsed into a persistent vegetative state as a result of his medication (a risk known to the patient). The court refused to grant permission even though it accepted the finding that Mr. Couture's expressions that he not be maintained by any artificial life support in the event of this precise occurrence were sufficient to "support the substituted judgment of the guardian."  

The reasoning in the *Couture* decision is questionable. The policy expressed by the court based on their interpretation of the DPAH is not supported by either an analysis of statutory language or legislative intent, according to Senator Richard Pfeiffer, the sponsor of the DPAH legislation. In addition, the *Couture* court's assertion that consent is an unimportant factor in the decision whether or not to withdraw nutrition

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10 Without a clear understanding of policy, abusive procedures may filter into clinical practice relating to the withholding of nutrition and hydration. Caregivers may become careless or arbitrary. Callahan, *Public Policy and the Cessation of Nutrition, By No Extraordinary Means* 63 (1986).


12 *Id.*

13 *Id.* § 1337.13.

14 *Id.* § 1337.13(A)(2).


16 *Id.* at 213, 549 N.E.2d at 576.

17 *Id.* at 214, 549 N.E.2d at 576.

18 Telephone interview with Senator Richard Pfeiffer, chief sponsor of Senate Bill 13 which became the Durable Power of Attorney for Health (Jan. 11, 1990) [hereinafter Sen. Pfeiffer] (conversation during which he said that he would have written an Amicus Brief that would have stressed, among other things, that guardians' powers were not affected by the statute.)
and hydration is highly questionable in light of *Cruzan v. Director, Missouri Department of Health.* in *Cruzan*, the Court recognizes the importance of the common-law doctrine of informed consent, assumes the existence of constitutional rights permitting consent to withdraw from artificial life support mechanisms, and leaves the question of how to enforce such rights in the hands of the states. Therefore, given the suspect logic, reasoning, and statutory interpretation of the *Couture* court, it seems unlikely that the decision will stand the test of time as a coherent expression of Ohio's policy concerning the refusal or withdrawal of nutrition and hydration.

To formulate a soundly reasoned policy, Ohio needs to reexamine its own common law, case law from sister states, and the Durable Power of Attorney for Health statute. In order to clarify existing patient and guardian rights, the formulated policy must determine in particular whether or not to consider nutrition and hydration mechanisms in the same light as other life support systems.

**II. DEVELOPMENT OF THE COMMON LAW**

**A. Treatment of Competents**

Competent individuals have decision-making powers that incompetents, because they are impaired by a disability, lack. Competent individuals are able to voice their own decisions concerning medical care. In emergency situations, under the doctrine of implied consent, a physician is permitted to begin procedures, including life support systems, necessary to save a person's life. This is because there is a presumption that the individual, if able to express his wishes, would want to live. Any such presumption regarding a choice of medical treatment can be rebutted effectively by a competent person. The right to make one's own medical decisions, even if unreasonable in the eyes of others, stems from the right of self-determination and individual autonomy. Consent is the exercise of this right of self-determination. Furthermore, consent must be informed to be valid.

20 *Id. at 2846-47.*
21 *Id. at 2851-52.*
22 *Id.*
23 Therefore, impliedly, a person would consent to a violation of his bodily integrity to preserve his own life. *Prosser and Keeton on the Law of Torts* 117 (5th ed. 1984) [hereinafter *Prosser and Keeton*].
24 Surrogate decision makers are unable to assume some risks for the incapacitated that he could have assumed for himself if he were competent. *Id.* at 115.
26 *Cruzan v. Director, Mo. Dept. of Health*, 110 S. Ct. 2841, 2847-49 (1990); *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 430, 497 N.E.2d 626, 633 (1986) (where wife was able to have a gastrostomy tube removed from her husband who was in a persistent vegetative state); See also *Prosser and Keeton*, supra note 23, at 866-67.
27 *Prosser and Keeton*, supra note 23, at 867-68.
Congrove v. Holmes, 28 an Ohio case, postulated that informed consent imposed a duty on a physician to inform his patient about probable consequences and risks, and the anticipated benefits of a suggested medical procedure.29 Informing a patient in advance of treatment enabled that patient to weigh the potential risks and benefits of the treatments as well as other available alternatives. The patient could then make an informed decision either consenting to or refusing the suggested procedure or treatment. Such consent was important according to the Congrove court because "[e]very individual has a right to the inviolability of his person which forbids a surgeon or a physician to invade the bodily integrity of his person."30

A later Ohio case, In re Milton,31 determined that the right to inviolability of bodily integrity extended to situations where the physician believed that treatment was necessary to save the life of the patient.32 In Milton, a patient was permitted to refuse potentially life-saving radiation treatments, transfusions and surgery.33 Although she was a psychiatric hospital patient, she was considered competent to make informed health care decisions. This was based on the fact that she had never been adjudicated an incompetent, and because the hospital had accepted her informed consent in making prior health care decisions.34

The courts in both Congrove35 and Milton36 accepted a competent's right to refuse life-sustaining medical treatments founded on the right of self-determination and expressed in the doctrine of informed consent.37 An-
other Ohio case, *Bruni v. Tatsumi*, explained that informed consent of the patient could be satisfied by information addressed to the spouse or parents. This is significant because it validates family participation in the decision-making process. In addition, *O'Brien v. Angley* held that informed consent was possible even when some information was omitted because of remoteness.

Jurisdictions outside Ohio have recognized the right of a competent person to have life-support systems removed. In *Georgia v. McAfee*, the court found that a competent quadriplegic had the right to disconnect his ventilator even though his condition was not terminal. The *McAfee* court ruled on the basis of informed consent, stating that McAfee was fully aware of the consequences of his decision. In recognizing a competent person's right to accept, refuse, or withdraw life-supporting medical procedures, the *McAfee* court applied the reasoning of *In re Farrell*, which stipulated that court approval of the disconnection of life-support systems was unnecessary when the patient was competent, and when he had been informed of his prognosis, the risks of withdrawing life-support, and of alternative treatments.

Although the Ohio cases do not record an instance where a competent person has been held to have a right to refuse artificial nutrition and hydration, at least one jurisdiction outside Ohio has spoken directly to this issue. In the California case of *Bouvia v. Superior Court*, the court recognized the right of self-determination in permitting a twenty-six year old quadriplegic of sound mental faculties to refuse artificial nutrition and hydration. She had understood the risks and consequences of her actions and had made an informed decision. Influencing the court was the fact that she was unable to fully feed herself due to her cerebral palsy. The court noted that she need not consent to procedures that she found burdensome and invasive.

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39 *Id.* at 137, 346 N.E.2d at 680. Although the elements of informed consent were satisfied, in this case it was a jury question whether the plaintiff had given consent to the higher risks of the specific operation performed on her. There was a lesser-risked, medically preferred alternative that her physician could have selected. *Id.*
41 *Id.*, (where incomplete disclosure of all possible side effects of a medical treatment did not necessarily negate informed consent). *Accord Couture v. Couture*, 48 Ohio App.3d 208, 549 N.E.2d 571 (1989), where “[i]t is not necessary that evidence show exactly what the ward would do in the precise circumstances at hand. Application of such a standard would impose impossible burdens as it could almost never be shown that the precise circumstances were anticipated.” *Id.* at 214, 549 N.E.2d at 576.
45 *Id.*
In general, a competent individual's right to refuse or accept medical interventions has been widely accepted even if these procedures are considered life-sustaining, as long as consent or refusal is informed. The Supreme Court in *Cruzan v. Director, Missouri Department of Health* recognized that "the common-law doctrine of informed consent ... generally encompasses the right of a competent individual to refuse medical treatment" and "assume[s] that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition" based on a Fourteenth Amendment liberty interest. Justice O'Connor, in her concurring opinion, takes an even stronger stand: "[A] duty [to give effect to the decisions of a surrogate decisionmaker] may well be constitutionally required to protect the patient's liberty interest in refusing medical treatment.

The right of self determination is not absolute, however, and must be weighed against any state interests. Traditionally, courts have refused to permit a patient to give informed refusal to a life saving treatment when the patient was curable and was a parent of a minor child, because the state had an interest in protecting the child from abandonment. This notion has recently been challenged by the decision in *Fosmire v. Nicoleau* where the court determined that a mother of an infant was permitted to refuse blood transfusions notwithstanding the state's interest in protecting the welfare of the child via the survival of its mother. The court held that the right to refuse treatment was the same in a parent or non-parent and that such right could not be undermined by claims of child abandonment.

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51 *Id.* at 2851.
52 *Id.* at 2852. The right to choose or refuse medical treatments can be derived from three sources: statutes, the common law, and the Constitution. Rights derived from each of these must be balanced with a state's four compelling interests. In order to properly weigh both sides, standards are needed. Adamson, *The Right to Refuse Life Sustaining Medical Treatment and the Noncompetent Nonterminally Ill Patient: An Analysis of Abridgement and Anarchy*, 17 PEPPERDINE L. REV. 461, 467, 473-75, 492 (1990). Perhaps the *Cruzan* Court was unwilling to wholeheartedly accept a constitutional right to die because it did not wish to undertake the formidable task of setting universal standards by which the right could be exercised. Since such an important issue needs consensus to properly work, the Court threw back the standard-setting questions to the states, the proper consensus-setting arenas. Mayo, *Constitutionalizing the “Right to Die”*, 49 MD. L. REV. 103 (1990).
53 *Cruzan v. Director, Mo. Dept. of Health*, 110 S. Ct. at 2851-52.
54 *Id.* at 2857.
58 *Id.* at 230-31, 551 N.E.2d at 83-84, 551 N.Y.S.2d at 882-83. This holding is contrary to past determinations in blood transfusion cases. Query whether the court was influenced by the fact that her refusal of the transfusions was motivated...
B. Treatment of Incompetents

An incompetent is defined by Ohio statute as "any person who is so mentally disabled as a result of mental or physical illness, or chronic substance abuse that he is incapable of taking proper care of himself or his property . . . ." The issue of incompetency is customarily raised by family members or health care personnel and is generally resolved outside of court even though the legal procedure is under the jurisdiction of the Probate Court. When it has been determined that a person is incompetent, the court may intervene on the incompetent's behalf, exercising its parens patriae power over the individual. In exercising its role as guardian over persons who are under a legal disability, the court defends the interests, including health and medical, of the incompetent that he is unable to defend for himself.

In the absence of court intervention, a physician will generally rely on the informed consent of the next-of-kin in making health care decisions for the incompetent. When the court becomes involved, in general, the preferred guardian is a relative — even a distant one. However, because the court is primarily interested in selecting a guardian who would be most likely to represent the best interests of the incompetent, it has sometimes selected close friends or distant relatives over close relatives.

In Ohio, the court may appoint the spouse as a guardian, or, when the incompetent has no acceptable guardian (for example, where there may not only by religious reasons, but by concerns of contracting AIDS or another communicable disease. Id. Perhaps it was this second reason that swung the balance in favor of preserving the mother's rights of inviolability over the state's interest in protecting the life of the child.

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59 OHIO REV. CODE ANN. § 2111.01(D) (Baldwin 1989).
60 DECIDING TO FOREGO, supra note 3, at 125.
61 OHIO REV. CODE ANN. § 2101.24(A)(6) (Baldwin 1987) stipulates that the Probate Court “make[s] inquests respecting persons who are unable to manage their . . . affairs effectively for reasons such as mental illness, mental deficiency, or physical illness or disability, subject to guardianship . . . .”
62 PARENS PATRIAE is the “role of state as sovereign and guardian of persons under legal disability . . . to protect . . . interests such as health . . . .” BLACK'S LAW DICTIONARY 1003 (5th ed. 1979).
63 1 PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS 185 (1982) [hereinafter 1 PRESIDENT'S COMMISSION]; T. BEAUCHAMP AND J. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 138 (2d ed. 1983) [hereinafter T. BEAUCHAMP AND J. CHILDRESS]; DECIDING TO FOREGO, supra note 3, at 124-5 n.11. This interpretation of the parens patriae power over incompetents is what is applied to once-competent incompetents who have not made directives for their future health care nor made their wishes known by others.
64 DECIDING TO FOREGO, supra note 3, at 125; 298 NEW ENGLAND J. MED. 508,508 (1978); Judges as Physicians, 14 U. CIN. L. REV. 161, 179 (1940); Kapp supra note 49, at 543.
65 Appointment or removal of guardians is within the jurisdiction of the Probate Court. OHIO REV. CODE ANN. § 2101.24(A)(4) (Baldwin 1983).
66 DECIDING TO FOREGO, supra note 3, 126-27 n. 18-19 & accompanying text.
be an adverse interest in the proceedings), the court may appoint another
guardian or guardian ad litem.68

Treatment of incompetent persons, where their wishes are unknown,
questionable, or unascertainable, favors prolonging life. This is based on
the concept that life itself, no matter what kind it is, is in the "best
interest" of the person.69 In the medical profession, case studies have
shown that when the attending physician believed that cardio pulmonary
resuscitation (CPR) was beneficial to the patient or CPR's benefits were
unclear, the incompetent patient was resuscitated regardless of the sur-
rogate decision-maker's preference for, neutrality to, or opposition to the
CPR.70 Even when CPR was deemed not beneficial to the patient in the
eyes of the physician, CPR was applied unless the surrogate decision-
maker opposed such treatment.71 This indicates a presumption in clinical
practice that the incompetent would favor receiving life-preserving treat-
ments.

Case law such as Ross v. Hilltop Rehabilitation Hospital72 also suggests
a presumption favoring life where the wishes of an incompetent could
not sufficiently be ascertained. In Ross, although the patient himself
articulated a wish to remove his gastrostomy tube, the court would not
consider those expressions because it considered that he lacked the ca-
pacity to give informed consent.73 Absent consent to remove lifesaving
equipment, the state's counter-balancing interests in preserving life and
preventing suicide are paramount. Thus, a presumption favoring life can-
not be overcome and the patient must remain on life-support.

In another case, In re Storer,74 the mother of an incompetent adult was

69 T. BEAUCHAMP AND J. CHILDRESS, supra note 63, at 143.
70 DECIDING TO FOREGO, supra note 3, at 247. This was in contrast to treatment
of competent patients. CPR was applied only when the patient favored or was
neutral to resuscitation, even if the physician felt that it would be beneficial to
the patient. When the patient opposed CPR, the treatment was not administered
regardless of the physician's assessment of its benefits. Id. at 244.
71 Id. This differs from CPR application to competent patients where CPR was
not deemed beneficial by the physician. In such situations, CPR was only applied
when the patient favored such treatment — not when he was neutral or opposed.
Id. Therefore, there was a strong presumption favoring life for incompetent indi-
viduals whose wishes were unknown whereas no such presumption existed in
competent individuals.
73 Id. at 1542 (The patient may have been suffering from a mental illness and
depression, had been addicted to drugs, and was undergoing severe stress due to
his impending divorce and deportation proceedings. These circumstances may
have been unduly affecting the patient such that he was unable to formulate any
decision concerning his gastrostomy tube.). This case provides an example of the
difficulty that may arise in defining competency. Dean Smith suggests that this
will be a significant problem in the future. S. Smith, Alternative Decision Making
for the Elderly: Durable, Springing and Health Care Powers of Attorney and Living
Wills 18 (April 1990) (unpublished manuscript given as address for the Elder
Law Continuing Legal Education Seminar). An explanation of current compe-
tency testing and testing proposals are discussed in Note, Determining Patient
74 In re Storer, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, cert. denied,
not permitted to exercise a substituted judgment for her son to discontinue the use of life-prolonging blood transfusions. This was because the court was unable to ascertain what her son, who had a mental age of eighteen months, would have wanted if competent. Without evidence that he would wish to discontinue life supporting blood transfusions, it was presumed that he would want to live, though his life expectancy even with transfusions was very short. The court determined that it was in his best interest to continue the transfusions.\(^\text{75}\)

C. Treatment of Once Competent Incompetents

1. Focus on the persistent vegetative state

This Note focuses on persons who are incompetent as a result of some trauma which has necessitated connection to a life support system\(^\text{76}\) and left them in a persistent vegetative state\(^\text{77}\) with a corresponding low level of brain function.

A person in a persistent vegetative state is one who has "the capacity to maintain the vegetative parts of neurological function but who . . . no longer has any cognitive function."\(^\text{78}\) Those in a persistent vegetative state, or pseudocoma,\(^\text{79}\) do not become conscious or responsive to the environment because, in some cases, the upper portion of the brain has been disconnected from the lower portion of the brain and nervous system.\(^\text{80}\)

\(^\text{75}\) Id.

\(^\text{76}\) There is widespread agreement among cases to permit the termination of life support in situations where the incompetent became severely and irreversibly brain damaged. See infra section on case law. If less severely damaged individuals were included in this discussion, the focus would shift from whether such termination is permitted at all, which is the issue here, to where to place the boundaries.

\(^\text{77}\) This is separate from a coma. Coma is defined as a "loss of consciousness." (GRAY, supra note 2, § 29A.20). Associated with awareness, consciousness is considered by some to be a necessary ingredient of life itself. Deep irreversible coma is an important determinative of brain death. Id.


\(^\text{79}\) Also known as "akinetik mutism, apallic syndrome, prolonged coma, coma vigile, parasomnia and locked-in syndrome." GRAY, supra note 2, at § 29A.70.

\(^\text{80}\) Id. The brainstem, or lower portion of the brain, is responsible for controlling vegetative functions such as swallowing. Higher brain functions are probably the result of the interaction between the upper portion of the brain and the brainstem. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DEFINING DEATH 15 (1981) [hereinafter DEFINING DEATH]. Others are not sure of our assessment concerning brain functions. They leave open the possibility that a person in this condition, although unable to respond to his environment, may still have a sense of self-awareness. P. RAMSEY, ETHICS AT THE EDGES OF LIFE 220-24 (1980).
Depending on the precise location of the disconnection, the person may retain some functions such as respiration. 81

A persistent vegetative state can also be the result of anoxia. Anoxia is a condition where the oxygen supply has been cut off, such as when respiration ceases or the heart stops pumping blood through the lungs and to the brain. 82 Although brain stem cells can survive 15-20 minutes without oxygen, 83 the brain’s cerebral cortex cells (associated with thinking and reasoning 84) can survive only a very short time. 85 Even though a person is resuscitated after durational anoxia has occurred, nerve cells within the brain, particularly in the cerebral cortex, have already died. Once dead, cells can never recover. Therefore, permanent brain damage results. 86

This Note is particularly concerned with victims of durational anoxia. It is these individuals who have no chance of recovery to a cognitive life and, consequently, have no place among the living or the dead. 87 They have no cognition, no awareness, no willful actions, no sense of pain or pleasure, but are not legally dead. 88 These unfortunates have the greatest need of relief.

Although there is no medical certainty concerning the life expectancy of individuals in a persistent vegetative state, some can survive for a relatively long time. Records reveal that survival of up to forty years is possible. 89 Therefore, it is important to determine a policy concerning life support systems which potentially may be used for a very long time.

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81 GRAY, supra note 2, § 29A.70. The ability of respiration and other metabolic functions decreases as the disconnection becomes lower and lower within the brain. Accompanying the early stages of pseudocoma is an inadequate respiratory function which would lead to death without a life support mechanism. However, there may be some slight recovery after adjustment to the condition. This explains why a person in a persistent vegetative state might eventually be weaned from his respirator. Id.

82 GRAY, supra note 2, at § 206.30. The cessation of respiration alone may not be sufficient to result in severe and permanent brain damage. As long as already oxygenated blood continues to flow to the brain, full or partial recovery can take place. However, circulation without respiration cannot prolong survival for very long since the blood becomes more and more oxygen-depleted each time tissues draw out the oxygen from the blood. Id. at § 206.40.


84 GRAY, supra note 2, at § 206.40 & see supra n. 80.

85 GRAY defines this time as only 1 minute without oxygen. Id., at § 206.30. The Cruzan Court accepts a more generous 4-6 minutes for the destruction of cerebral cells from oxygen deprivation. Cruzan, 110 S. Ct. at 2868 n.8 (Brennan, J. dissenting).

86 GRAY, supra note 2, at § 206.40; DEFINING DEATH, supra note 80, at 17,18.

87 DECIDING TO FOREGO, supra note 3, at 10; GRAY, supra note 2, at § 29A.00.


89 DEFINING DEATH, supra note 80, at 18.
2. Case law

People who were once competent but have sunk hopelessly and irreversibly into a state of persistent vegetation have been permitted to authorize the discontinuation of their life support mechanisms.\(^9\) The seminal case in Ohio, *Leach v. Akron General Medical Center*,\(^9\) held that the respirator could be disconnected in a case involving a seventy-year old incompetent in a chronic vegetative state of very low brain activity. No civil or criminal liability was attached to those participating in the decision or the process of disconnection.\(^9\) The court based its decision primarily on the constitutional right of privacy\(^9\) which "guarantees to an incurably, terminally ill person, who is in a permanent, vegetative state, the right to decide future medical treatment."\(^9\) A subsequent case, *Leach v. Shapiro*,\(^9\) based its affirmation of the right of an incompetent to refuse life saving procedures on the doctrine of informed consent. The court stipulated that a patient had a right to refuse life saving treatments when he could "satisfy the same standards of knowledge and understanding required for informed consent."\(^9\) Thus, a patient has the right in Ohio to refuse life saving treatments when he can foresee the circumstances which might place him in a state of persistent vegetation.\(^9\)

As a case of first impression in Ohio, the *Leach* court relied on decisions from other jurisdictions. The first state to decide the issue of whether artificial life support could be disconnected from an incompetent person was New Jersey. In the case *In re Quinlan*,\(^8\) the Supreme Court of New Jersey extended the right of privacy first established by the United States Supreme Court in *Griswold v. Connecticut*\(^9\) to a patient's ability to refuse treatment.\(^9\) A person's right to decline treatment must be balanced

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\(9\) Id.

\(9\) Although the Court in *Cruzan* questions whether the privacy right extends to the refusal of medical care, it does not deny that a 14th Amendment liberty interest would extend such constitutional protection. *Cruzan* v. Director, Mo. Dept. of Health, 110 S. Ct. 2841, 2852, 2857 (1990) (O'Connor, J. concurring).

\(8\) *Leach*, 68 Ohio Misc. at 12, 426 N.E.2d at 816. It is significant that the court termed her prognosis of death in three to five years from her disease as terminal. It was based on the use of terminal by the physician. This differs from the definition of "terminal condition" in the DPAH.


\(9\) Id. at 397, 469 N.E.2d at 1053.

\(9\) Id.


\(9\) *Griswold v. Connecticut*, 381 U.S. 479 (1965) (where the constitutional right of privacy, derived from the Bill of Rights, precluded judicial intrusion in a couple's choice regarding the use of contraception).

\(10\) *Quinlan*, 70 N.J. at 40, 355 A.2d at 663.
against the state's interests, but at some point, an individual's rights outweigh the state interests.\textsuperscript{101} In Karen Quinlan's case, her inability to emerge from a state of persistent vegetation to a "cognitive, sapient state"\textsuperscript{102} was factually determinative in outweighing the state's interest in preserving life. In the decision to permit the disconnection of her respirator, the \textit{Quinlan} court held that "the State's interest \textit{contra} weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims."\textsuperscript{103} The court held that since a competent person in similar circumstances could make a decision to withdraw from artificial life support systems, even if death was a consequence, then an incompetent person is also so entitled, if his wishes to do so are known.\textsuperscript{104}

To preserve Karen's interest against bodily invasion, the \textit{Quinlan} court used the substituted judgment of her parents.\textsuperscript{105} The court was unable to find a clear expression of Karen's wish to refuse life support in casual conversation with her friend. However, the court noted that other jurisdictions\textsuperscript{106} had used the substituted judgment of surrogates in order to implement medical decisions and authorize treatment for incompetents. When a substituted judgment was found to be consistent with the patient's desires, the state could determine that such decision by the surrogate was in the best interests of the patient and therefore useful in the exercise of the state's \textit{pares patriae} responsibility toward the incompetent.\textsuperscript{107} The desires of the incompetent were to be decided on the basis of whether or not the incompetent would view the medical procedures as intrusive.\textsuperscript{108} The importance of a substituted judgment and a pleading by

\begin{footnotesize}
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\item[\textsuperscript{101}] \textit{Id.} at 41, 355 A.2d at 664.
\item[\textsuperscript{102}] \textit{Id.} at 55, 355 A.2d at 671.
\item[\textsuperscript{103}] \textit{Id.} at 41, 355 A.2d at 664. Although the \textit{Quinlan} court couched the ability to withdraw treatment in terms of invasiveness, other courts did not seem to use the \textit{Quinlan} balancing test. Other courts such as \textit{Brophy} spoke in terms of what the patient viewed as invasive. Thus, the focus on "objective" standards of invasive treatment shifted to protecting a patient's decision-making values. Peters, \textit{The State's Interest in the Preservation of Life: From Quinlan to Cruzan}, 50 Ohio St. L.J. 891, 897-900 ((1989).
\item[\textsuperscript{104}] \textit{In re Quinlan}, 70 N.J. at 39, 355 A.2d at 663 (The \textit{Quinlan} court relied on the parents as surrogate decision-makers to determine Karen's wishes.).
\item[\textsuperscript{105}] For an excellent explanation of standards of decision-making, see Note, \textit{Privacy, Family, and Medical Decision Making for Persistent Vegetative Patients}, 11 Cardozo L. Rev. 713, 725-29 (1990).
\item[\textsuperscript{107}] \textit{Id.} at 40-41, 355 A.2d at 663-64.
\item[\textsuperscript{108}] \textit{Id.} (where Quinlan's respirator was considered an "extraordinary" means of keeping her alive, and therefore could be disconnected. \textit{Id.} at 31-33, 48, 335 A.2d at 658-60,668). The permission to terminate all "extraordinary" treatment and the denial of permission to terminate all "ordinary" measures is confusing. Some equate "extraordinary" with "not frequently done." Others say something is "extraordinary" if it involves a technically advanced apparatus. \textsc{deciding to forego}, \textit{supra} note 3, at 84. A more reasonable approach, in accord with Catholic teaching, is the proportionate/disproportionate view on the medical intervention. It is looked at from the point of view of the patient, weighing his burdens and benefits. Prolonging his life is not always considered an automatic benefit. It is examined in light of all the circumstances to determine what is in the patient's
\end{enumerate}
\end{footnotesize}
third parties on the incompetent's behalf was to preserve the incompetent's rights of self-determination which otherwise would be lost.\textsuperscript{109}

Although the \textit{Cruzan} Court does not adopt the theory that the right to refuse medical treatments falls within the constitutional right of privacy, it does not deny constitutional protection. Instead, the Court states that "this issue is more properly analyzed in terms of a Fourteenth Amendment liberty interest."\textsuperscript{110} The Court also concedes that the right to refuse life support founded on a liberty interest "may be inferred from our prior decisions."\textsuperscript{111}

In the case of \textit{In re Eichner},\textsuperscript{112} the common-law right of self-determination was determinative in holding that an eighty-three year old individual in a persistent vegetative state was able to have his respirator removed. The \textit{Eichner} court reaffirmed that the rights of self-determination of an incompetent did not disappear when he became incompetent: \textquote{"[B]y standards of logic, morality and medicine the terminally ill should be treated equally, whether competent or incompetent."}\textsuperscript{113} The \textit{Eichner} court stipulated that refusal of medical treatment was valid under circumstances where it would only prolong suffering needlessly, or would "serve merely to denigrate his conception of the quality of life."\textsuperscript{114}

\begin{flushright}
\textit{In re Eichner, 73 A.D.2d 431, 426 N.Y. Supp. 2d 517 (1980).}\hfill
\textit{Id. at 464, 426 N.Y. Supp. at ... Accord Leach v. Akron Gen. Medical Center, 68 Ohio Misc. 1, 426 N.E.2d 809 (1980); Superintendent of Belchertown State School v Saikewicz, 373 Mass. 728, 370 N.E. 417 (1977) (where the right of privacy and informed consent extends to incompetent persons in refusing life support mechanisms); \textit{In re Quinlan}, 70 N.J. 10, 35 A.2d 647 (1976).}\hfill
\textit{Eichner, 73 A.D.2d at 464, 426 N.Y.Supp.2d at 542.}\hfill
\textit{Id. at 458-59, 426 N.Y. Supp.2d at 539. Accord Brophy v New England Sinai Hosp., 398 Mass. 417, 497 N.E.2d 626 (1986) (where decision to forego life support was based on a competent's right of self-determination, and not an outsider's viewpoint). This concept that quality of life is determined by an individual's conception is superior to the \textit{Quinlan} quality of life argument which was based on definitions of extraordinary and ordinary care. See \textit{supra} note 108. The desirability of treatment ought to be founded on a personal feeling of bodily intrusion rather than on someone else's fluctuating, external standard of ordinary or extraordinary care. One must assume some kind of quality of life standard if burdens and benefits are to be weighed in formulating a decision that is in the best interests of the patient. T. BEAUCHAMP AND J. CHILDRESS, supra note 63, at 134. This contrasts with the views of others who believe that by using some kind of quality of life standard, even if based on a patient's presumed perspective, it will force a "wedge" into the sanctity of life and permit the possibility of euthanasia. Note, \textit{A Hypothetical: Quinlan Under Ohio Law}, 10 \textit{AKRON L. REV.} 145, 164 (1976). Others are concerned that adopting any quality of life approach puts an unde-
The Eichner court, like the Quinlan court, said that substituted judgment was valid in determining what an incompetent would decide for himself if competent. In Eichner, however, unlike Quinlan, the patient had clearly expressed his desire not to be maintained on life support systems should he fall into a persistent vegetative state.\textsuperscript{116}

The Eichner situation bears resemblance to the Ohio case, \textit{Leach v. Akron General Medical Center}.\textsuperscript{117} The Leach court held that a respirator could be disconnected from an incompetent woman who, when competent, had clearly and convincingly expressed an intent to refuse life support. The court examined testimony by seventeen witnesses concerning the prognosis of irreversible brain damage and her desire not to be placed on life support systems. At the time of the cardiac arrest and subsequent connection to artificial life support, Mrs. Leach was already in a terminal condition with amyotrophic lateral sclerosis. She knew that she would become incapacitated and die within three to five years.\textsuperscript{118} Conversations just two days before her incapacity revealed her dread of being placed on life support: "That's the one thing that terrifies me. I don't want to be put on life support systems. I don't want to live if I have to be a vegetable."\textsuperscript{119} This, the Leach court determined, was clear and convincing evidence of the intent of Mrs. Leach not to consent to the use of artificial life support. Therefore, it was sufficient to support the substituted judgment of her family to disconnect her respirator.\textsuperscript{120}

When physicians or hospitals do not comply with a patient's refusal of life support, the Ohio case of \textit{Estate of Leach v. Shapiro}\textsuperscript{121} held that a cause of action for battery exists.\textsuperscript{122} For competent patients, this cause of action accrues immediately upon nonconsensual bodily invasion. With incompetent individuals, however, there is a presumed consent akin to the implied consent in emergency situations because, as in an emergency, the incompetent's wishes are not immediately discernible. Therefore, it is presumed that the individual would wish to save his own life.\textsuperscript{123} The

\textsuperscript{116}Eichner, 73 A.D.2d 431, 426 N.Y.Supp.2d 517 (1980). Used as clear and convincing evidence of Brother Fox's intent not to continue the use of the respirator were his oral expressions that he "would not want any of this extraordinary business... to be done for him" when discussing the Quinlan case in serious discussions. \textit{Id.} at 440, 426 N.Y. Supp.2d at 526. In addition, Brother Fox was in agreement with Pope Pius XII's allocutio which had been discussed in conjunction with the Quinlan case. In the formal address before anesthesiologists, the Pope stated that there was no obligation to treat patients beyond ordinary care, that a respirator fell outside the ordinary care category, and that disconnection of the respirator was only an indirect cause of death. \textit{Id.} at 439 n.3, 426 N.Y. Supp.2d at 526.

\textsuperscript{117}Leach v. Akron Gen. Medical Center, 68 Ohio Misc. 1, 426 N.E.2d 809 (1980).

\textsuperscript{118}Id.

\textsuperscript{119}Id. at 4, 426 N.E.2d at 811.

\textsuperscript{120}Id. at 12-13, 426 N.E.2d at 816.

\textsuperscript{121}Leach v. Shapiro, 13 Ohio App. 3d 393, 469 N.E.2d 1047 (1984).

\textsuperscript{122}Id.

\textsuperscript{123}PROSSER AND KEETON, supra note 23, at 117.
Shapiro court, however, warned against using the implied consent doctrine to continue lifesaving treatment where it would undermine the incompetent's right to refuse such treatment. Where it could be shown that an express refusal to consent to treatment existed, as in the Leach case, "an implied agreement [could not] thereby arise..." Thus, the presumption in favor of the life-preserving procedure is effectively rebutted when the express wishes of an incompetent clearly and convincingly establish that he would not desire such bodily intrusion. Therefore, a cause of action for battery will exist if a physician and/or hospital disregards the incompetent's desire to refuse treatment.

The intrusiveness of life support has been addressed by several courts. According to the Supreme Judicial Court of Massachusetts in Brophy v. New England Sinai Hospital, intrusiveness should be examined in light of each patient's personal viewpoint. The Brophy court determined that "the law recognizes the individual's right to preserve his humanity, even if to preserve his humanity means to allow the natural processes of a disease or affliction to bring about a death with dignity." The court maintained that it was not forcing anyone to accept a judgment based on its own view on the value of life. Instead, the court held that its duty to preserve life encompassed a "recognition of an individual's right to avoid circumstances in which the individual himself would feel that efforts to sustain life demean or degrade his humanity." Thus, it is not the court, but the individual himself who determines what is personally degrading. This degradation is measured by how intrusive the patient feels the treatments are rather than by some external, inconsistent measure of what is considered extraordinary or ordinary care. A New Jersey Supreme Court case, In re Conroy, supports the idea that invasion of one's bodily integrity should be determined by the individual and not the state. The Conroy court determined that "the primary focus should be the patient's desires and experiences of pain and enjoyment — not the type of treatment involved." This reasoning, based on the rights of self-determination and informed consent, was applied to the removal of nasogastric tubings.

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124 Shapiro, 13 Ohio App. 3d at 396, 469 N.E.2d at 1053.
126 Id. at 434, 497 N.E.2d at 635; Accord Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); In re Conroy, 93 N.J. 321, 486 A.2d 1209 (1985). See also quality of life discussion supra note 115. This contradicts the suggestion that a decision to terminate life support imposes an outside view of the quality of life on a person making the decision for himself. What is suggested only is that the person issuing the directive make his own evaluation for himself.
127 Brophy, 398 Mass. at 434, 497 N.E.2d at 635.
128 Id.
129 Id. See also supra note 108.
131 Id. at 369, 486 A.2d at 1233.
133 In re Conroy, 93 N.J. 321, 486 A.2d 1209 (1985) (In this circumstance the tubing was not removed because there was insufficient evidence of the patient's intent.)
Although the courts express a desire to base decisions concerning the removal of nutrition/hydration devices on the patient's wishes, the question still remains: What would the incompetent really want if he were able to make an informed decision at the precise moment it were needed? Consistent standards are needed to establish the degree of certainty that courts require in determining what would be consistent with the incompetent's wishes if he could express them.

In *Cruzan v. Harmon*,134 Nancy Cruzan was not permitted to have her gastrostomy feeding and hydration tubing removed via her parent surrogate decision-makers. The Missouri Supreme Court determined that a clear and convincing evidentiary standard must be satisfied in order to remove the life-sustaining tubing,135 and that in Nancy's case such an evidentiary standard had not been met.136 The Supreme Court in *Cruzan v. Director, Missouri Department of Health*,137 upheld the decision of the Missouri Supreme Court. The five to four decision focused on the ability of states to determine their own standards, and on Missouri's clear and convincing burden of proof standard. The U.S. Supreme Court held that a procedural safeguard such as a "clear and convincing" proof standard was not unconstitutionally high because the "risk of an erroneous decision [should be borne by] . . . those seeking to terminate an incompetent individuals life-sustaining treatment."138

The *Leach*139 court, interpreting Ohio law, selected the clear and convincing standard to support a substituted judgment for an incompetent concerning the disconnection of a respirator.140 It would appear that this same standard would, in light of *Cruzan*, be appropriate for making decisions to terminate nutrition and hydration providing that Ohio considers the administration of nutrition and hydration to those unable to ingest in the same light as other life support systems.141

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134 760 S.W.2d 408 (Mo. 1988).
135 Id.
136 Id. at 417.
138 Id. at 2856.
140 Id.
141 Many jurisdictions accept nutrition/hydration as any life support care. E.g., *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 497 N.E.2d 626 (1986); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985). It is so accepted by the American Academy of Neurology and the American Medical Association. *Cruzan v. Director, Mo. Dept. of Health*, 110 S. Ct. 2841 (1990) (Brennan, J. dissenting). Nevertheless some argue that artificial nutrition and hydration ought to be treated differently than respirators and other artificial mechanisms: that it is always ordinary, and, therefore, never optional. Note, *Artificial Nutrition and the Terminally Ill: How Should Washington Decide?*, 61 WASH. L. REV. 419, 421 (1986). However, there are others who believe that it more clearly resembles medical treatment; therefore it should be medically decided. *Society for the Right to Die, The Physician and the Hopelessly Ill Patient* 12 (1984). Childress, a noted biomedical ethics scholar, believes that it would be morally wrong to use life-sustaining treatment on a once-competent incompetent against his wishes. *By No Means, supra* note 108, at 77,78. *See infra* notes 150 - 60 & accompanying text; *Kapp, supra* n. 49, at 553. There is still an argument that nutrition/hydration devices should be treated separately from a humanitarian viewpoint because prolonged pain would
In conclusion, the once-competent incompetent's rights are best explained by incorporating the right of self-determination found within the common-law doctrine of informed consent which applies to competent patients, with the parens patriae responsibility of the state toward its incompetent wards. This merging can be accomplished by examining the evidence to determine if the incompetent, prior to his incompetence, expressed a desire not to undergo life-sustaining treatment, and whether the evidence of the incompetent's express directive satisfies the clear and convincing standard set by Leach. If it does, then the patient should be able to refuse or discontinue all life support via the substituted judgment of his surrogate, absent a court's determination that compelling state interests mandate continuing the life-sustaining treatments.

If, however, the once-competent incompetent gave no express directives nor gave any clear or convincing expression of his intent, there would be insufficient evidence to support the substituted judgment of a guardian in making a decision to disconnect life support. The court would then need to exercise its parens patriae responsibility over its ward's best interests as though he had never been competent. In such a situation, the presumption that the person would choose to live is irrebuttable because there is no supportive evidence that he would choose not to prolong his life. The incompetent must remain on life support systems because the state's interest in preserving life is the sole determinative factor in the court's decision.  

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The principles of beneficence and autonomy require a presumption favoring life. By No Means, supra note 108, at 77. See also Prosser and Keeton, supra note 28, at 117. This may at some point be challenged by one of two arguments. There is an argument that the state's interest in life cannot be so compelling since the state does not require citizens to procure necessary medical care, nor does it carry enough health insurance to support the medical assistance to all those in need. Cruzan v. Director, Mo. Dept. of Health, 108 S. Ct. 2841, 2870 n.15 (1990) (Brennan, J. dissenting). Another argument can be viewed from a utilitarian approach. If life-sustaining machinery is required even in cases where the intent of the incompetent was known, as the need for such technical equipment increased, the money needed to sustain such activity may be taken from other important health needs. At that point, the distribution of available wealth may very well necessitate an approach which terminates life-sustaining machinery on persistent vegetative patients, notwithstanding some of their wishes to be sustained. For an allocation of resources analysis, see G. Graber, A. Beasley, and J. Eaddy, Chapter 5, Who Gets What? and Appendix I, More About Ethical Theories, Ethical Analysis of Clinical Medicine (1985).

Although this may be reprehensible for some, others will accept such determination as part of a double-effect philosophy. Under the doctrine of double-effect, there is a distinction between results that are direct versus indirect consequences of a person's actions. A person who takes pain medicine and subsequently dies is viewed differently from a person who, under otherwise exact circumstances,
3. State interests

The individual's rights of self-determination are not absolute, but should be respected as long as the decision stemming from those rights is not outweighed by one of four compelling state interests. The Leach court identified these four significant state interests as: (1) the preservation of life; (2) the prevention of suicide; (3) the maintenance of the ethical integrity of the medical profession; and (4) the protection of third parties. They must be balanced with the right of self-determination expressed in any decision to forego artificial life support.

In Leach, the court determined that the state's interest in preserving life was not compelling enough to outweigh an individual's autonomy when an incompetent was incurably and terminally ill and in a persistently vegetative state. Other jurisdictions agreed that the state's interest in preserving life was very high with curable illnesses and relatively low with illnesses and injuries resulting in a permanent, incurable, vegetative state. The state's interest in the preservation of life takes the precise dose for the purpose of killing himself and subsequently dies. In the first example, death was an indirect consequence of the pain medication, whereas in the second example, ingestion of the pain medication was a direct cause of death. See Quinn, Actions, Intentions, and Consequences: The Doctrine of Double Effect, 18 PHILOSOPHY AND PUBLIC AFFAIRS 334 (1989); Mayo, Constitutionalizing the "Right to Die," 49 MD. L. REV. 103, 140-41 n. 203 (1990). The termination of life support measures would be viewed not so much as the killing of the persistent vegetative patient, but of providing expensive medical care alternatively to individuals who are recoverable with treatment. In this light, the death of the patient whose life-sustaining machines have been disconnected, will be a sad, but indirect result.

Leach v. Akron General Medical Center, 68 Ohio Misc. 1, 426 N.E.2d 809 (1980).

143 The purposes behind a state's interest in life is four-fold: to protect a patient's welfare, protect his wishes, enforce community beliefs about the sanctity of life, and to steer clear of the slippery slope erosion. If one does not protect the sanctity of all life, it is feared, in the slippery slope argument, that permitting withdrawal of life-sustaining procedures in some cases will lead to the condoning of suicide. Peters, The State's Interest in the Preservation of Life: From Quinlan to Cruzan, 50 OHIO ST. L.J. 891, 893, 962 (1989).


Although the decision was ultimately expressed by a surrogate on the patient's behalf, it was upheld because such decision was clearly and convincingly expressed by the patient herself at a time prior to her incompetency.

Leach, 68 Ohio Misc. 1, 426 N.E.2d 809 (1980).

is not so compelling as to override a person's right to determine his own medical treatment when there is evidence of his express desires.\textsuperscript{149}

The question remains, however, whether a person's right to refuse treatment overrides a state's interest in preserving life and preventing suicide when nutrition/hydration life support is involved. Further, would the withdrawal of nutrition and hydration be considered within the legal definitions of killing or suicide?

Jurisdictions which have decided cases involving the termination of nutrition and hydration of a patient have reasoned that the refusal or withdrawal of nutrition and hydration was neither killing nor suicide because such action was merely considered an intention not to prolong life by artificial means.\textsuperscript{150} In \textit{Brophy}, the court determined that the affliction that made swallowing impossible was the killing agent, not the removal of feeding tubes. Death resulted from neither killing nor suicide, but from natural causes, and was not intended by the patient.\textsuperscript{152} In \textit{Conroy}, the appellate court agreed: "Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury."\textsuperscript{154}

In \textit{Leach}, disconnection of life support was not considered suicide because "[s]uicide requires a specific intent to die. Withdrawal of a respirator evinces only an intent to forego extraordinary measures, and allows the processes of nature to run their course."\textsuperscript{166} Suicide was not established because disconnecting the life support did not indicate an intent to die. Nor was disconnection considered the proximate cause of death.\textsuperscript{157} Since the disconnection cannot be considered killing or suicide by the reasoning above, the state's interest in these matters cannot be compelling enough to override a person's consent to disconnect or refusal to connect onto a life support system.


\textsuperscript{150} See \textit{In re Conroy}, 98 N.J. 321, 486 A.2d 1209 (1985), (where rejecting nasogastric tube was not attempting suicide); Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983); Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986) (where her wish to die was interpreted to mean that she was willing to accept death as a natural consequence of her unwillingness to accept the burdensome invasion of constant care required by her disease).

\textsuperscript{152} Id.

\textsuperscript{153} \textit{In re Conroy}, 98 N.J. 321, 486 A.2d 1209 (1985).


\textsuperscript{157} In State v. Johnson, 56 Ohio St. 2d 35, 381 N.E.2d 637 (1978), the court determined that cause of death was the trauma that eventually led to the connection to life support in the first place.
Many believe that the definition of life support should include the artificial delivery of nutrition and hydration. Jurisdictions outside of Ohio, as well as the American Academy of Neurology and the American Medical Association consider artificial means of nutrition and hydration as a form of medical treatment no different from respirators and other types of life-sustaining medical care. The legal ability of patients or their surrogates to disconnect respirators from once-competent incompetent patients is well documented. When life support includes nutrition and hydration along with respiration, its disconnection should not be considered killing or suicide. Therefore, the state's interest in preserving life or preventing suicide should not be compelling enough to override a person's wish to refuse nutrition and hydration by artificial means.

Another state interest, maintaining the integrity of the medical community, according to the Leach court, was deemed not to have been compromised when a respirator was disconnected from a patient who was in an incurable and persistent vegetative state. The integrity of the medical community could not be compromised by the disconnection of artificial nutrition and hydration if, as a whole, the community felt that termination was either appropriate or at least not contrary to their medical ethics. The President's Commission has recommended that each health care institution establish an in-house ethics committee to study and resolve ethical issues raised by requests to abstain from or terminate life-sustaining treatments within their institutions. Many, if not most, hospitals already have a functional ethics committee. In fact, an institutional ethics committee was involved in the Quinlan decision as early as 1976. Although not required to do so, the committee could adopt the standards of representative organizations of the health care community such as the American Medical Society and the American Academy of Neurology. Both organizations have declared that termination of artificial nutrition and hydration is acceptable where the patient is in an irreversible vegetative state. A professional's medical integrity, however, can be affronted in spite of the philosophies of health care organizations. To avoid compromising personal standards of medical integrity, the law should not force any hospital or individual physician to carry out the wishes of the incompetent to disconnect feeding tubes. To recognize both the values of the patient desiring the cessation of artificial nutrition and hydration and the conflicting values of the health care professional or institution which, because

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157 Cruzan, 110 S. Ct. at 2867 n.7 (Brennan, J. dissenting).
158 Id. at 2867.
160 Leach, 68 Ohio Misc. 1, 426 N.E.2d 809 (1980).
161 DECIDING TO FOREGO, supra note 3, at 5.
162 MAKING HEALTH CARE DECISIONS, supra note 63, at 187.
of ethical considerations, cannot justify the discontinuation of the patient's nutrition and hydration, courts need to permit the qualifying person to be moved to a hospital that will carry out his wishes, and/or transfer health care of the patient to a physician who will comply with the patient's desire to forego treatment. This is essentially what courts in other jurisdictions have done. 167

Finally, the state's interest in protecting innocent third parties was considered minimal in Leach since there were no minor children involved. 168 Other states generally have not found third party interests compelling. 169 Thus, the rights of the patient to discontinue or refuse treatment prevailed over the combination of state interests.

Under Ohio's common law, state interests have not been deemed compelling enough to outweigh the interests of the persistent vegetative incompetent where there was clear and convincing evidence that the person would choose not to prolong his life in such a condition. 170 Ohio has a firm foundation in the common law to extend this outlook to cases involving the termination or refusal of artificial nutrition and hydration, as has been the case in other jurisdictions. 171

III. ARTIFICIAL NUTRITION AND HYDRATION IN OHIO

A. Introduction

Under the common law in Ohio prior to the recently-enacted Durable Power of Attorney for Health (DPAH) statute, a guardian was able to


168 Leach v. Akron Gen. Medical Center, 68 Ohio Misc. 1, 426 N.E.2d 809 (1980). It is difficult to imagine a situation where a third party's right to protection would be greater than the incompetent's privacy right to determine his own medical treatment when he is in a non-cognitive, irrecoverable condition. Perhaps it might arise on the insurance level where companies construe policies in such a way as to force a policy-owner in making a health care decision contrary to his deep-seated personal views on whether disconnecting artificial life support is killing. To avoid such catastrophe, it is imperative that the legislature intervene. Health insurance policies should be forbidden from imposing penalties on those who did not wish to terminate artificial life support. In addition, life insurance companies should not be permitted to withhold payment from beneficiaries of policy-holders who chose to terminate life support and subsequently die. If the state determined that such refusal or withdrawal was neither killing or suicide, the insurance companies should not be allowed to withhold payment on those grounds. Thirty-five of the thirty-nine states with living will legislation have provisions whereby the living will document has no effect on health or life insurance. Note, Comparison of the Living Will Statutes of the Fifty States, 14 J. OF CONTEMP. LAW 105, 123-29 (1988).


exercise a substituted judgment for the incompetent. By this means, medical treatment could be refused or withdrawn if there were clear and convincing evidence of the incompetent’s intent to prevent such bodily intrusion. Life support could be terminated after the courts determined that state interests in preserving life, preventing suicide, preserving the integrity of the medical profession, or protecting innocent third parties were not sufficient to outweigh the incompetent’s right of self-determination.

The common law permitting a guardian to plead to the court for the disconnection of life support mechanisms on behalf of the once-competent incompetent must now be reexamined in light of the DPAH. Although the recent decision in Couture expressed the opinion that the common law regarding the disconnection of life support has been superseded by the DPAH, an interpretation of the statute in light of its plain language and legislative intent strongly suggests that the common law rules remain intact. Contrary to the Couture opinion, guardians have not been limited by the statute in the making of health care decisions for the principal. What has been changed by the statute is that now attorneys in fact selected under the statutory provision, as well as guardians, have an ability to make health care decisions for the principal in most circumstances.

B. The Durable Power of Attorney for Health

The DPAH enables a competent adult to execute a document naming another person of his choice that he has freely selected as his attorney in fact. This attorney in fact is permitted to make decisions for the

172 Leach, 68 Ohio Misc. 1, 426 N.E.2d 809.
174 Leach, 68 Ohio Misc. 1, 426 N.E.2d 809.
177 Id. at 213, 549 N.E.2d at 575-76.
178 OHIO REV. CODE ANN. § 1337.13(A)(2) (Baldwin Supp. 1989) reads, in pertinent part: “This section does not affect ... any right that the person designated as attorney in fact ... may have, apart from the instrument, to make or participate in the making of health care decisions on behalf of the principal.”
180 The OHIO REV. CODE ANN. excepts decisions refusing or withdrawing comfort care (§ 1337.13(C)) or life support, unless the principal is in a statutorily defined terminal condition (§ 1337.13(B)).
181 OHIO REV. CODE ANN. §§ 1337.11 - 1337.17 (Baldwin Supp. 1989). For a comparison with the prior durable power statute, formal guardianship and living trusts, see Fabens, Ohio’s Durable Power of Attorney, 2 OHIO LAWYER 9 (1988).
182 There are limitations against selecting medical personnel indirectly related to any health care decisions OHIO REV. CODE ANN. § 1337.12(A) (Baldwin Supp. 1989). There are also plans to modify the statute so that only directly related personnel will be prevented from being named attorneys in fact. Sen. Pfeiffer, supra note 18.
183 Not a symbol of profession, but of relation to the principal, or the one who executed a Durable Power of Attorney for health document.
principal only when the principal becomes incompetent. Such power
can be revoked at any time by the grantor because there is always a
presumption that the principal is competent.

The statute grants power to the attorney in fact to give informed consent
or informed refusal to medical treatments for the principal. To this end,
the attorney in fact has the same right that the principal has to receive
medical information in order to make an informed decision. In addition,
the principal can give some directives in advance of illness or injury so
that medical decisions will be made which are consistent with his
desires.

There are advantages in permitting an attorney in fact to make deci-
sions generally made by a guardian for the incompetent. The primary
benefit is that an attorney in fact, unlike a guardian, does not need to
expend the time, money, and effort of court proceedings in order to become
effective as a decision-maker. An attorney in fact’s powers vest im-
mEDIATELY upon a determination of the incompetency of the principal.
Although a determination of incompetency may need court adjudication
in some circumstances, once determined, there is no need to prolong court
time and money in selecting a suitable decision-maker when a durable
power of attorney document has been executed by the incompetent while
he was still competent.

Another advantage in executing a durable power of attorney document
is that a principal can specify the person to whom he wishes to entrust
the guardianship of his liberty rights. This chance for advance selection
enables the principal to choose someone who would be most likely to

184 Ohio Rev. Code § 1337.12(A)(1) (Baldwin Supp. 1989). As such, this is a
"springing" power that takes effect, not immediately, but at the instance of in-
competency. S. Smith, Alternate Decision Making for the Elderly: Durable, Spring-
manuscript); Kapp, supra note 49, at 548.

the DPAH, see Carlson, Ohio’s New Law: Durable Power of Attorney for Health
Care Decisions, Cleveland Physician (1989).


187 Unless a restriction has been written onto the document form by the prin-

188 Ohio Rev. Code Ann. § 1337.17 (Baldwin Supp. 1989) provides a form where
they can be written in.

which reads in pertinent part: "(T)he attorney in fact shall act consistently with
the desires of the principal or, if the desires of the principal are unknown, shall
act in the best interests of the principal."

190 A guardian needs court approval for such legal capacity. Ohio Rev. Code

191 We will have to see to what extent, if any, such appointment can be chal-
enged by others. However, a presumption would be in favor of the attorney in
fact since the court generally appoints someone it feels will preserve the best
interests of the incompetent. See discussion supra notes 61-68 & accompanying
text. Since the principal already designated this person, it is presumed he would
be looking after his own interests, or at least that his decision should be respected
barring a finding that the attorney in fact selected is inappropriate.

192 See Kapp, supra note 49, at 545.
make the same informed decisions that he would make for himself if he were able. Thus, in addition to saving the time, money, and effort required in a court proceeding, there is greater certainty that the most suitable decision-maker has been selected. It would not be surprising if the attorney in fact turned out to be the same person that the court would have chosen as guardian. Advance selection by the principal, however, creates a presumption of the suitability of the attorney in fact that is strong enough to dispense with the necessity of his approval by court.195

A final advantage provided by the DPAH is that documented directives can be furnished by the principal in advance of their need.196 This ensures greater certainty that the informed consent or refusal is consistent with the decision of the principal in so far as he was able to foresee his own condition and choice of treatments.

Under the DPAH statute, an attorney in fact has authority to make health care decisions for the principal during the principal's incompetency.197 He has the ability to substitute his judgment for the principal in making decisions consistent with the principal's desires.198 He must follow advance directives except where they have been shown not to have the effect that the principal wished.199 The attorney in fact also has the ability to consent to the disconnection of life support, including artificial nutrition and hydration (or refuse to consent to its initiation) when the principal is in a terminal condition.200

See supra note 3 & accompanying text.
195 See supra note 189 & accompanying text.
197 Ohio Rev. Code Ann. § 1337.13(B) (Baldwin Supp. 1989) in pertinent part states: "An attorney in fact . . . does not have authority . . . to refuse or withdraw . . . health care that is necessary to maintain the life of the principal, unless the principal is in a terminal condition."
198 Ohio Rev. Code Ann. § 1337.13(E) (Baldwin Supp. 1989) reads, in pertinent part: "An attorney in fact . . . does not have authority to refuse or withdraw . . . the provision of nutrition or hydration . . . unless . . . (1) . . . [it] would not provide comfort care . . . ; (2) . . . either . . . (a) . . . death . . . is imminent . . . ; [or] (b) . . . [it] could not be assimilated or would shorten the life . . . ."
199 The attorney in fact's authority to terminate nutritional and hydrational life support is emphasized in Ohio Rev. Code Ann. § 1337.16(B) (Baldwin Supp. 1989) which reads, in pertinent part:

No physician who . . . refuses to comply with the instructions of an attorney in fact . . . to withhold or withdraw health care necessary to keep the principal alive that were given under Division (A) of section 1337.13 of the Revised Code shall prevent . . . the transfer . . . to the care of a physician who will comply with the instructions . . . .

Section 1337.13(A) stipulates that a valid power of attorney has been created pursuant to section 1337.12, and that the circumstances when refusal or withdrawal occur be limited, in part, by the stipulations above. Ohio Rev. Code Ann. § 1337.13(A) (Baldwin Supp. 1989).

In stipulating that regardless of what the principal designates in the DPA document "... the attorney in fact NEVER will be authorized to . . . " disconnect life support unless death is "imminent" even with it; or to refuse or disconnect artificial nutrition or hydration unless death is imminent, the statute is really granting the attorney in fact the power to disconnect life support, even nutrition
There are, however, limitations on an attorney in fact. He cannot exercise his substitute judgment in refusing (or withdrawing) consent to artificial nutrition or hydration unless certain criteria are met. Termination of nutrition or hydration by the principal's attorney in fact are permitted only when: (1) death is imminent regardless of medical care; (2) when nutrition or hydration would harm the patient or would not help him survive; and (3) nutrition and hydration would not provide comfort. In fact, the attorney in fact may not refuse or withdraw consent to any life support unless the principal's death is imminent. The statute also refuses to allow the withdrawal of comfort care or to refuse or to disconnect life support in most cases where the principal is pregnant.

These limitations on the power of the attorney in fact in matters of informed refusal or withdrawal of any artificial life support (not just artificial nutrition and hydration) are consistent with the common law policy requiring court supervision when life support systems are to be removed from an incompetent whose death is not imminent. Under the common law, state interests must be weighed against a person's right of self-determination before a decision to disconnect life-sustaining ma-
chines can be supported. In cases where death is imminent, the state's interest in the preservation of life is minimal. Therefore, a decision to terminate life support in those cases does not conflict with any compelling state interests and can be effectuated without court supervision. In cases where a patient may be terminal but where death is not imminent, the only way in which the state can preserve its interests in the preservation of life, prevention of suicide, protection of third parties, and safeguarding the integrity of the medical community is by examining each case in court where the termination of life support becomes an issue. Without the appropriate safeguards of court supervision, an attorney in fact could abuse his powers. Therefore, the court still needs to examine whether the substituted judgment is supported by clear and convincing evidence of the incompetent's intent as set forth in Leach. The Court held that a clear and convincing evidentiary standard, such as the one mandated by Leach in Ohio, is constitutional when used to decide whether to terminate nutrition/hydration devices from a once-competent incompetent person who is in a state of persistent vegetation.

205 See supra Section II.C.3. on State Interests.
206 Because of the necessity of court intervention to terminate but not necessarily to begin life support in the first place, it is easier simply to avoid the legal and emotional conflicts by never beginning treatment. Courts are reluctant to impose liability on inaction. Byrn, Compulsory Lifesaving Treatment for the Competent Adult, 44 Fordham L. Rev. 1, 9 (1975). Some feel that withdrawing treatment is worse than not beginning. Lynn and Childress, supra note 108, at 55. But such inaction is really worse because it is necessary to begin aggressive treatment to save those who might otherwise recover. One cannot assess a prognosis without initial intervention under the doctrine of implied consent. The Hastings Center, Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying 130 (1987). If the courts make termination more difficult, this unfortunate result may occur which would go against the court's intent.

207 For instance, the attorney in fact might be influenced by some personal benefit in deciding one way or another. He might not properly interpret the directives. The document might be outdated, forged, or represented by someone other than the person who claims to be the attorney in fact.

208 Leach v. Akron Gen. Medical Center, 68 Ohio Misc. 1, 426 N.E.2d 809 (1980). The DPAH document clearly states that an attorney in fact would never be able to terminate life support in statutorily-defined non-terminal conditions. Ohio Rev. Code Ann. § 1337.17 (Baldwin Supp. 1989). It also clearly states that advance directives may be issued: "You may express your desires... by including them in this document or by making them known to him in another manner." Ohio Rev. Code Ann. § 1337.17 (Baldwin Supp. 1989). By inference, although directives which ask that life support be terminated or refused in situations of irreversible persistent vegetative state could not be carried out by the attorney in fact, there is no reason why they could not be used by the court as evidence of the principal's intent. The court did not limit the principal in making such directives; it only limited the ability of the attorney in fact to implement them without court intervention. The court could then make a case by case determination of whether such evidence was clear and convincing and whether it was compelling enough to outweigh the state's interests pursuant to Leach.

209 Id.
211 Id. at 2862. See supra notes 134-38 & accompanying text.
The DPAH indirectly supports the view of court adjudication in situations of non-imminent death because it directs that any rights granted by the statute are separate from any rights the attorney in fact might otherwise have.\textsuperscript{212} His guardianship authority under the common law, apart from the statute, remains intact.\textsuperscript{213} Thus, guardians have the ability to handle situations involving life-sustaining machinery in situations other than the ones outlined in the statute.\textsuperscript{214} While an attorney in fact may not enforce a decision to disconnect the life support from the incompetent, as guardian he may still plead, and win, such termination from the overseeing court. Senator Richard Pfeiffer, sponsor of Senate Bill 13 before its enactment into the Durable Power of Attorney for Health, confirms this interpretation.\textsuperscript{215} The DPAH gave the maximum authority possible to attorneys in fact while preserving the integrity of the common law.

Thus, the policy behind the limitation of the attorney in fact's powers is to preserve the court's ability to protect the incompetent's rights and to balance them with state interests.\textsuperscript{216} Such limitations are unnecessary to impose on a guardian because legally, a guardian is already bound by the court's supervisory powers in matters regarding the disconnection of life support from an incompetent who is not terminally ill.\textsuperscript{217}

The DPAH does not change the common law procedures which can be used by a guardian. The statute clearly stipulates that a guardian preserves whatever rights and powers he had under the common law in these matters apart from the statutory authority he may have in addition as attorney in fact.\textsuperscript{218}

\textbf{C. Couture v. Couture: A Misinterpretation of the Statute}

Through 1988, there were no Ohio cases determining whether or not an incompetent who was once competent could choose to refuse or ter-

\textsuperscript{212} \textbf{Ohio Rev. Code Ann.} § 1337.13(A)(2) (Baldwin Supp. 1989) reads in pertinent part: "This section does not affect ... any right that the person designated as attorney in fact ... may have, apart from the instrument, to make or participate in the making of health care decisions on behalf of the ... powers remained unchanged and were separate from whatever powers that same person may have had as attorney in fact.

\textsuperscript{213} \textit{Id.} § 1337.13(A)(2).

\textsuperscript{214} Sen. Pfeiffer, \textit{supra} note 18.

\textsuperscript{215} \textit{Id.}

\textsuperscript{216} It is not, as the \textit{Couture} court suggests, a policy to prevent any disconnection of nutrition or dehydration. \textit{See infra} notes 255-56 & accompanying text.

\textsuperscript{217} \textit{See Leach v. Shapiro, 13 Ohio App. 3d 393, 469 N.E.2d 1047 (1984). One author suggests that without court supervision, there is a danger that decisions will be made not in the best interests of the incompetent, but in the best interests of the physicians, hospital, family, or society. Solnick, Withdrawal and Withholding of Life-Support in Terminally Ill Patients. Part II, 4 Medicine and Law 1, 7-8 (1985).

minate artificial nutrition and hydration life support systems. The development of the common law in Ohio can be attributed to the decisions in *Leach*\(^{219}\) and *Shapiro*\(^{220}\) which held that respirators could be disconnected from terminally ill incompetent persons who, by clear and convincing evidence, could be ascertained to have made a choice for their future medical care while they were competent to do so.\(^{221}\) These cases relied on the privacy rights expressed in *Quinlan*\(^{222}\) and the doctrine of informed consent utilized in *Eichner*\(^{223}\) to allow third parties to use their substituted judgement on behalf of the incompetent in order to preserve his rights.\(^{224}\) Since *Leach*, other jurisdictions have applied these same principles of self-determination and personal autonomy to the refusal or withdrawal of artificial nutrition and hydration. California,\(^{225}\) Delaware,\(^{226}\) Massachusetts,\(^{227}\) and New Jersey\(^{228}\) cases have permitted refusal or withdrawal of artificial nutrition and hydration. Last year Ohio had a chance to decide whether it would follow the lead of these states.

Early in 1989, Daniel Couture became comatose and is now in a persistent vegetative state with virtually no chance for recovery.\(^{229}\) He is unable to sense pain. No longer on a respirator, he retains a feeding tube for nutrition and hydration, but he is expected to die in a matter of months due to the collection of fluid on his brain.\(^{230}\) His mother, family members, his physician and hospital, the American Medical Association, the American Academy of Neurology, and his guardian-ad-litem all agreed that termination of the feeding tube was in his best interest, and that he would desire such withdrawal.\(^{231}\) Couture had, on several occasions, declared

\(^{222}\) In re *Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976).
\(^{223}\) In re *Eichner*, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980).
\(^{225}\) See *Bouvia* v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986) (where hospital could not force feeding tubes on a competent adult); *Barber* v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) (where physicians who withdrew IV tubing from a brain-damaged patient were held not liable).
\(^{226}\) See *Severns* v. Wilmington Medical Center, 425 A.2d 156 (Del. Ch. 1980) (where court permitted withdrawal of nasogastric tubing from comatose auto accident victim).
\(^{228}\) In re *Conroy*, 98 N.J. 321, 466 A.2d 1209 (1985) (where patient who died before finalization of case would not have been forced to accept nasogastric tubing and its resultant pain).
\(^{230}\) *Id.* at 210-11, 549 N.E.2d at 573.
\(^{231}\) *Id.* at 211-12, 549 N.E.2d at 574.
that he did not want to prolong his life by artificial systems. These state-
ments were made with the realization that there was a risk that his medica-
tion might cause him to become incompetent and fall into a per-
sistent vegetative state. Unfortunately, the risk did materialize and re-
sulted in Couture's present irreversible vegetative state. In spite of
these facts, which the Couture court conceded were "adequate to support
the substituted judgment of the guardian," the court held that his
guardian was unable to consent to the removal of nutrition and hydration
tubes. The court reasoned that any other decision would be contrary to
the public policy as outlined in the DPAH since the "General Assembly["
was opposed to the withdrawal of nutrition or hydration under these cir-
cumstances [non-imminence of death] notwithstanding the wishes of the
patient or his surrogate."

Such an interpretation of the DPAH is highly questionable in light of
the Supreme Court's reasoning in Cruzan. Contrary to Couture, Cruzan
does not dispute a person's right to make an informed choice regarding
the withdrawal of nutrition and hydration. Rather, it finds difficulty with
how an incompetent person's wishes could be ascertained with the degree
of certainty necessary for a surrogate decision-maker to exercise those
rights. Cruzan encourages states to set their own standards and accepts
the clear and convincing standard used in Missouri and Ohio (for deter-
mining whether other life support mechanisms could be refused or with-
drawn) as appropriate for making decisions regarding nutrition and
hydration.

The Couture court's rationale is also highly questionable in light of the
language and legislative intent of the DPAH statute. Couture misapplies
the DPAH to guardians, misapplies the statutory definition of "terminal,"
and implies an erroneous distinction between nutrition/hydration and
other life support methods.

232 Id. at 209, 213-14, 549 N.E.2d at 572-73, 576.
233 Id. at 214, 549 N.E.2d at 576.
234 Id. at 214, 549 N.E.2d at 576.
235 Id. This decision came out a month before the statute was in effect. Therefore, there was no such thing under Ohio law as an attorney in fact for health matters. It may also be interesting to note that Couture did not refer to the newly enacted guardianship statute in OHIO REV. CODE § 2111.13(D) (Baldwin 1989) which specifically grants guardians the power to make health care decisions for the incompetent. Carlson, Ohio's New Law: Durable Power of Attorney For Health Care Decisions, CLEVELAND PHYSICIAN 6 (December 1989).
236 Couture, 48 Ohio App.3d at 213, 549 N.E.2d at 576.
238 Id. at 2852. See supra notes 50-54, notes 110-11, and notes 136-38 & accom-
panying text.
239 Id. at 2856. There is an argument that the family is the best decisionmaker.
Note, Privacy, Family, and Medical Decision Making for Persistent Vegetative Patients, 11 CARDOZO L. REV. 713 (1990). Another author believes that a "best interests" standard is preferable since no one can ever really give a clear expres-
sion of what he will believe is the right decision at the moment it must be made. Thus, the decision should be made by those persons closest to the incompetent at the time it is needed. Moreover, court adjudication, he believes, should be utilized only when no suitable decisionmaker is available. Schultz, Procedures and Limitations for Removal of Life-Sustaining Treatment from Incompetent Patients, 34 ST. LOUIS U. L. J. 277, 300-305 (1990). These viewpoints, however, do not take into account the increased risk of abuse without court supervision.

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1. Misapplication of the DPAH to guardians. The statute does not in any way indicate a drift away from what was accepted under the common law concerning the disconnection of life support. On the contrary, the DPAH expressly provides for the maintenance of guardianship powers when it states that:

   This section does not affect, and shall not be construed as affecting any right that the person designated as attorney in fact in a durable power of attorney for health care may have, apart from the instrument, to make or participate in the making of health care decisions on behalf of the principal.239

Further, when the DPAH is read in conjunction with the new Ohio guardianship statute that specifically recognizes the powers of a guardian to make health care decisions for an incompetent it is clear that the DPAH was not envisioned by the legislature as superceding a guardian’s common law powers.240 In addition, other jurisdictions, unlike the Couture court, have interpreted statutory limitations as not applying to guardian rights and powers.241

2. Misapplication of the statutory definition of “terminal condition” to guardians. In the DPAH, “[t]erminal condition’ means any illness or injury that is likely to result in imminent death, regardless of the type, nature, and amount of health care that is provided.”242 This definition is different from the one utilized by the Leach court in its interpretation of Ohio common law.243 Mrs. Leach’s condition was regarded as terminal when her prognosis for death was within three to five years. The Leach court accepted the medical usage of the word “terminal.” Subsequently, her respirator was ordered disconnected by the court after they had determined (through the substitute judgment of her guardian and family) that it would be her wish to do so.244

If the Couture court had used the Leach definition of terminal condition, the medical determination that Daniel Couture would die within months would permit the disconnection of life support.245 The Couture court, however, chose to abandon the common law adjudication and use the statutory definition of terminal instead, to prevent Couture’s guardian from carrying out Couture’s clearly expressed wishes. Since Couture’s death was not “imminent” by statutory definition, he was unable to have the feeding

239 OHIO REV. CODE ANN. § 1337.13(A)(2) (Baldwin Supp. 1989). Sen. Pfeiffer, supra note 18, also states that the statute was not meant to supercede guardian powers. See also Kapp, supra note 49, at 549.

240 OHIO REV. CODE § 2111.01(A) (Baldwin 1989).


244 Id.

245 Sen. Pfeiffer, supra note 18.
tubes disconnected. What the Couture court did not seem to understand was that "terminal condition" needed to be narrowly drawn in the DPAH statute in order to grant the attorney in fact powers that did not nullify the court's protection of the incompetent's autonomy and its own state interests. Nowhere in the text of the statute does it indicate that this narrow definition of terminal condition is to be imposed on the common law powers granted to a guardian. Contrary to the Couture court's finding, the statute specifically provided that the statute did not change any powers that the attorney in fact had as a common law guardian.

3. Nutrition/hydration distinction. The Couture court opined that the DPAH had defined "best interests" of the incompetent, as a matter of law, to preclude consent to withdraw means of artificial nutrition and hydration, in spite of the incompetent's clear desires to avoid such intrusion on his body. The statutory provision regarding an ability to terminate life support, however, was not limited to nutrition and hydration. It is clear from the statute that all life support mechanisms fall under the same limitations. The particular specifications regarding artificial nutrition and hydration serve to clarify the point at which artificial nutrition and hydration could be disconnected without court supervision. Thus, the policy in the statute does not proscribe the termination of nutrition and hydration per se as the Couture court suggests. Instead, it recognizes that it is in the best interest of the individual to have the final decision open to court supervision.

As a case of first impression, the narrow holding in Couture to refuse permission to withdraw artificial nutrition and hydration from any incompetent could have been acceptable. There is evidence that some judges are unhappy with their colleagues' majority decision to permit such a withdrawal. In addition, there is some controversy among philosophers as to whether artificial nutrition and hydration should be distinguished from other life support mechanisms. However, the Couture court's broad

247 See supra notes 85-155, 244 & accompanying text.
250 OHIO REV. CODE ANN. § 1337.13(B) (Baldwin Supp. 1989) reads: "An attorney in fact under a durable power of attorney for health care does not have authority, on behalf of the principal, to refuse or withdraw informed consent to health care that is necessary to maintain the life of the principal, unless the principal is in a terminal condition"; Sen. Pfeiffer, supra note 18.
252 Some argue that food and water are symbols of care and compassion and, therefore, can never be withheld. On the other hand, means of artificially feeding and providing moisture are really more similar to other medical procedures than to eating and drinking. Other life-support withdrawals such as discontinuation of dialysis or transfusions have similar effects to malnutrition or dehydration. Lynn and Childress, supra note 108, at 57-58. Even the states of malnutrition or dehydration are determined chemically; they are not synonymous with the hunger and thirst that we abhor. The Hastings Center, GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND THE CARE OF THE DYING 59-60 (1987). See also supra notes 141, 182.
decision to prevent disconnection of artificial nutrition and hydration based on statutory policy as outlined in the DPAH is erroneous because it failed to understand the reason for the narrow definition of "terminal" adopted by the statute, the nutrition/hydration distinction, and both of these as relating to guardians.253

D. Setting Ohio on Course

The decision in Couture,254 while misinterpreting and misapplying the DPAH statute, now stands as a possible precedent for future Ohio case law. The statute was not intended to change, but to complement, the common-law power of guardians. Nor was it designed to foist a narrow, statutory definition of "terminal" on the courts. The statute intended that guardians and courts be free to accept the medical determination of "terminal" adopted by the Ohio courts in Leach.255 The Ohio legislature must now take appropriate action to clarify its position in light of the Couture decision.256 Until it does, Ohio courts will be left straddling the line between accepting the holding in Couture, or ignoring Couture and taking the proper stand on the withdrawal of nutrition and hydration based on sound reasoning and a valid interpretation of the DPAH statute.

The legislature could clarify the DPAH by expressly stating that guardians can still make decisions regarding the removal of life support, including nutrition and hydration, from an incompetent. In addition, the legislature must clarify the use of advance directives concerning the withdrawal of life support. Although an attorney in fact may not terminate life support pursuant to the incompetent's advance directives within the DPAH, the directives could be used as evidence of the incompetent's intent. Therefore, even though the attorney in fact was unable to execute the principal's request of life support termination himself, under the supervision of the courts he, or another who would be appointed as the principal's guardian, could effectuate the principal's medical choice to terminate life support. Ideally, the directives would satisfy the requirements of informed consent as espoused by the court in Shapiro.257

An alternative course of legislative action would include legislative approval of a "living will" document enabling a person to express his intent prior to becoming incompetent. Other jurisdictions have such "liv-

253 Sen. Pfeiffer, supra note 18.
255 Sen. Pfeiffer, supra note 18.
256 Id.
257 Leach v. Shapiro, 13 Ohio App. 3d 393, 397, 469 N.E.2d 1047, 1053 (where the doctrine of informed consent permitted that "[g]eneral statements by the patient could still be considered by a court, of course, in determining the wishes of a patient in a chronic vegetative condition." Id.). See supra notes 32-46 & accompanying text. The DPAH document provides a form enabling advance directives to be made by the principal. OHIO REV. CODE ANN. § 1337.17 (Baldwin Supp. 1989). See also F. ROUSE, THE PHYSICIAN AND THE HOPELESSLY ILL PATIENT 7 (1985).
ing will” documents. Some states expressly approve of a principal’s ability to make advance directives for the termination of all life support systems, including artificial nutrition and hydration, in the living will document. Dicta in *Cruzan* supports written documentation as the best means of expressing intent. In this manner, the principal could exercise his autonomy rights and advance directives for the consent to, refusal of, or termination of artificial life support systems.

If the Ohio legislature does not choose to enact “living will” legislation or to clarify the DPAH statute for the courts, then Ohio is faced with the risk of continued misinterpretation of the DPAH statute, which threatens the right of its citizens to choose death with dignity.

Although there is always the possibility that a future case may arise which would provide Ohio courts with the opportunity of properly interpreting the DPAH statute regarding the withdrawal or refusal of nutrition and hydration in a once-competent incompetent who is in a persistent vegetative state, there are also grave dangers in this approach. A later case may claim stare decisis and, like *Couture*, refuse to consider the true issues while following the holding of *Couture*. Another danger is that physicians, fearful of lawsuits, may make medical decisions they believe are not in the best interests of their patients. Thus, legislative action is needed to eradicate any possible effects of the flawed *Couture* decision and assure that future Ohio cases are decided in accord with the true meaning and purpose of the DPAH statute.

IV. CONCLUSION

The development of aggressive medical life saving and life-sustaining technology has led to the necessity for a coherent and humane policy dictating when they may be refused or withdrawn. The common law in Ohio has established that a competent person may refuse or withdraw

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258 “Living wills” are legislatively-approved documents whereby a person can document their desire not to be maintained on life support systems should they become terminally ill and incompetent. Note, *Comparison of the Living Will Statutes of the Fifty States*, 14 J. of Contemp. Law 105 (1988).

259 Id. at 121-29. Ohio has no living will statute. Id. at 127. For a contrary view that living wills should not be used, see Mayo, *Constitutionalizing the “Right to Die”*, 49 Md. L. Rev. 103, 145 (1990)(An executor might feel obliged to discontinue life support even though he does not want to.).

260 *Cruzan* v. Director, Mo. Dept. of Health, 110 S. Ct. 2841, 2856 (1990); “These procedures for surrogate decisionmaking [living will and durable power of attorney statutes], which appear to be rapidly gaining acceptance, may be a valuable additional safeguard of the patient’s interest in directing his medical care.” Id. at 2858 (O’Connor, J. concurring).


262Although there is a proposal in the House now, it seems unlikely to pass without outside incentive. Such legislation has been introduced and failed several times. Sen. Pfeiffer, *supra* note 18.

263 Kapp, *supra* note 49.
life support. If, however, the person is incompetent, life support may be withdrawn when clear and convincing evidence validates the substituted decision by the guardian of the incompetent to discontinue life support measures. Before ordering a termination of the life support of an incompetent, the court must weigh the rights of the individual that would be invaded by life support maintenance against conflicting state interests. If the incompetent's rights outweigh the state's interest in preserving life, preventing suicide, preserving the integrity of the medical profession, and protecting innocent third parties, then disconnection is ordered.

Several jurisdictions have included the artificial means of nutrition and hydration within the definition of life support. Ohio has not formulated a coherent policy. On the one hand, Couture has proscribed the termination of nutrition and hydration from an incompetent in a persistent vegetative state. On the other hand, the Couture court based its decision on an erroneous interpretation of Ohio's new Durable Power of Attorney for Health statute.

The DPAH, contrary to Couture's explanation, preserved the supervisory responsibility of the court in deciding whether or not to forgo all life support (not just nutrition/hydration) whenever death was not imminent. The statute did not change the authority of a guardian to decide treatment for an incompetent. Instead, the statute gave the maximum power possible to the attorney in fact to make decisions for the principal. The attorney in fact could even effectuate, without court supervision, a refusal or withdrawal of nutrition and hydration maintenance within the statute when physicians determined that such life support would not be helpful, would not provide comfort, and when death was imminent.

Couture caused confusion in Ohio's determination of whether to permit a once-competent incompetent individual to direct his future decisions regarding nutrition and hydration. If Ohio wishes to treat nutrition and hydration life support in a different manner than other life support measures, it should do so for sound medical, moral, and legal reasons; not for false or arbitrary ones.

Ohio has yet to adopt a policy regarding the refusal or withdrawal of nutrition and hydration. New legislation or new cases can help if they resolve the key issues: Should Ohio accept the proposal that artificial nutrition and hydration is indistinguishable from other life-sustaining systems and follow the lead of many states that permit their termination? Or, should the repugnance of the physical deterioration of a malnourished, dehydrated human being be so strong that deprivation of food and water in all cases must be forbidden?

JUNE MARY ZEKAN MAKDISI

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