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Senate Bill 1, Ohio's Advance Directives Law: Where Have We Been...Where Are We Going?

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I. INTRODUCTION

On October 10, 1991, Ohio's Advance Directives Law, Amended Substitute Senate Bill Number 1 (hereinafter "Senate Bill 1"), became effective in the State of Ohio. Senate Bill 1 addresses both the Living Will and the Durable Power of Attorney for Health Care, (hereinafter "DPAHC") and also makes provisions if no advance directive has been executed. Under the new law, Ohioans can execute a Living Will and/or a DPAHC to indicate their preferences for future health care needs.

Since September 27, 1989, Ohio has had a statute recognizing the DPAHC. The initial DPAHC statute allowed an individual to designate one or more persons to make health care decisions on his or her behalf in the event of incapacity. Although the statute's purpose was to provide a means for expressing one's wishes regarding continuation or withdrawal of certain health care measures in specific circumstances, the statute was unsatisfactory in many ways. The amendments to the statute contained in Senate Bill 1 are intended to improve and clarify the terms of the DPAHC.

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1 Advance directive is a general term which applies to both Living Wills and Durable Powers of Attorney for Health Care. See infra notes 3 and 4.

2 Amended Substitute Senate Bill No. 1 was signed by Governor George V. Voinovich on July 11, 1991 with an effective date of October 10, 1991.

3 Ohio Rev. Code Ann. §§ 2133.01 through 2133.15 (Baldwin 1992) contain the statutory definitions and provisions of Ohio's Living Will Declaration legislation. The formal name of the statute is the Modified Uniform Rights of the Terminally Ill Act. Under this Chapter a Living Will is defined as a document which permits a competent adult to "declare" his or her intentions regarding health care in the event of the individual's incapacity.

4 Ohio Rev. Code Ann. §§ 1337.11 through 1337.17 (Baldwin 1992) contain the statutory definitions and provisions for the Durable Power of Attorney for Health Care. Under these sections, a DPAHC is defined as a document which permits an individual to designate one or more persons to make health care decisions on his or her behalf in the event of incapacity.

5 If no advance directive has been executed the individual is known as a "nondeclarant."


7 § 1337.13(A)(1).

8 The primary deficiencies of the statute were: (1) the DPAHC did not have a standard state mandated form; (2) it only permitted the withholding of life sustaining measures if in a terminal condition and death was imminent (the court in Couture v. Couture, 549 N.E.2d 571 (Ohio 1989) construed "imminent" as some time period less than one or two months); (3) the DPAHC had a limit of 7 years after which time the document was no longer valid; and (4) the provisions concerning withholding of nutrition and hydration were ambiguous and confusing.
Senate Bill 1 also adds new provisions allowing for any competent adult to "declare" his or her wishes for health care in the event he or she is in a terminal condition or permanently unconscious state. The declaration is the first legislation in Ohio which recognizes a living will as a valid legal document. A living will is not a legally binding instrument unless a statute authorizes the right to refuse medical treatment in an official act.

This article will discuss in Part II, the pertinent case history in Ohio and in other jurisdictions which built the foundation for advance directive legislation in Ohio. Part III will review the legislative history which led to the passage of Senate Bill 1; and Part IV will discuss how Senate Bill 1 interacts with the Federal Patient Self-Determination Act which went into effect on December 1, 1991. Part V will analyze how the implementation of Senate Bill 1 has affected doctors, nurses and health care facilities. Finally, Part VI will cover how information about advance directives is being disseminated to the general public and what ideas are being implemented for the future.

II. CASE LAW PRECEDING PASSAGE OF SENATE BILL 1

Case law has been the foundation for the introduction and subsequent passage of Ohio's Advance Directives Law. Cases starting with In re Quinlan 12

9 A "terminal condition" is defined as an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by a declarant's or other patient's attending physician and one other physician who has examined the declarant or other patient, both of the following apply: (1) there can be no recovery; [and] (2) death is likely to occur within a relatively short time if life sustaining treatment is not administered. § 2133.01(AA).

10 A "permanently unconscious state" is defined as a state of permanent unconsciousness in a declarant or other patient that, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by the declarant's or other patient's attending physician and one other physician who has examined the declarant or other patient, is characterized by both of the following: (1) the declarant or other patient is irreversibly unaware of himself and his environment; [and] (2) there is a total loss of cerebral cortical functioning, resulting in the declarant or other patient having no capacity to experience pain or suffering. § 2133.01(U).

11 Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388 (1990). The Federal PSDA requires that all Medicaid and Medicare providers inform patients of their rights regarding self-determination for health care and record whether the patient has executed an advance directive. Further, the providers must educate their personnel regarding these matters. Failure to comply with the PSDA could result in providers losing their Medicare and Medicaid payments.

through *Cruzan v. Director, Missouri Department of Health* brought the issue of patient autonomy to the forefront of American awareness. Through these cases, new issues were litigated regarding patient autonomy and a constitutional right of refusal of medical treatment. These court decisions alerted the legislature to the myriad problems which could arise in this area. Senate Bill 1 is Ohio's answer to these difficult situations.

**A. Case Law From Other Jurisdictions**

*In re Quinlan* was the first case of significance to be decided regarding "right-to-die" litigation. In this cornerstone case, and in three subsequent New Jersey cases, the New Jersey Supreme Court confirmed its opinion that an individual's right of self-determination over his or her own body survives legal incompetency. The facts of the case were that Karen Quinlan was a healthy female who, at the age of twenty-two, lapsed into a persistent vegetative state. Medical experts determined that she would not recover. Karen's father sought to have her respirator disconnected, but her physician refused. Karen's father applied to be appointed guardian, with the express power to discontinue medical treatment. The New Jersey Supreme Court, using the "substituted judgment" test in which the court asks "what would the patient's decision have been?" decided that Karen's decision would have been to discontinue life-support. The court stated that the state's interest "weakens and the individual's right to privacy grows as the degree of bodily invasion increases"

13 *497 U.S. 261 (1990).*


15 In *re Jobes*, 529 A.2d 434 (N.J. 1987) (holding that the right of a patient in a persistent vegetative state to make life-sustaining treatment decisions may be exercised by the patient's family, close friends or guardian); In *re Peter*, 529 A.2d 419 (N.J. 1987) (empowering the Office of the Ombudsman for the Institutionalized Elderly to be involved in the decision-making process with the family members, close friends or guardians when the individual never clearly expressed their preferences while competent and the life-sustaining treatment issue concerns an elderly adult residing in a nursing home); In *re Conroy*, 486 A.2d 1209 (N.J. 1985).

16 The term "persistent vegetative state" ("PVS") is a term which is frequently misused and misunderstood. A complete clinical analysis of a patient in a PVS will be left to authors who are much more qualified to interpret and define its complex medical symptoms. For such an analysis, see Ronald E. Cranford, *The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)*, HASTINGS CENTER REP., February/March 1988, at 27. For the purposes of this article, the simplified definition of a person in a PVS is someone whose brainstem continues to control reflexes and functions such as respiration, heartbeat and digestion, but who is "completely . . . unaware of him or herself or the surrounding environment." *Id.* at 28.

17 The doctrine of substituted judgment is one which is used by the courts when no advance directive exists. See Sanford H. Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 CAL. L. REV. 857 (1992).
and the prognosis dims. Ultimately there comes a point at which the individual’s rights overcome the State interest."18 There are a substantial number of state and federal cases which have subsequently been decided on the right of privacy issue which was predicated in Quinlan.19 These right of privacy cases have laid the foundation for the development of law in this area.

A second line of cases were based on the liberties protected by the Fourteenth Amendment’s Due Process Clause.20 The most highly publicized case in this area is Cruzan v. Director, Missouri Department of Health.21 In Cruzan, the U.S. Supreme Court specifically declined to address the right of privacy issue, and instead analyzed the issue as a Fourteenth Amendment Due Process Clause liberty interest.

The facts of Cruzan were that Nancy Cruzan, after being severely injured in a car accident on January 11, 1983, was declared by physicians to be in a persistent vegetative state (hereinafter "PVS"). After almost five years in a PVS, Nancy’s parents, as her court appointed guardians, sought removal of her nutrition and hydration22 which was being received through an artificial feeding tube. The hospital, however, refused to remove the feeding tube, forcing Nancy’s parents to seek a court order. The trial court held that Nancy had a fundamental state and federal constitutional right to refuse "life-prolonging" measures, and directed the hospital to honor the family’s request to withdraw her nutrition and hydration. The case was appealed to the Missouri Supreme Court which reversed the trial court’s decision,23 holding that

[w]e find no principled legal basis which permits the Co-Guardians in this case to choose the death of their ward. In the absence of such a legal basis for that decision and in the face of this State’s strongly stated policy in favor of life, we choose to err on the side of life, respecting

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18Quinlan, 355 A.2d at 664.


20U.S. CONST. amend. XIV, § 1.


22Hydration means fluids that are artificially or technologically administered. OHIO REV. CODE ANN. §§ 2133.01(N) and 1337.11(M) (Baldwin 1992).

Nutrition means sustenance that is artificially or technologically administered. §§ 2133.01(T) and 1337.11(S).

23Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988).
the rights of incompetent persons who may wish to live despite a severely diminished quality of life.\textsuperscript{24}

The case was then appealed to the U.S. Supreme Court which affirmed the decision of the Missouri Supreme Court that an incompetent patient’s refusal of life-sustaining medical treatment must be proved by clear and convincing evidence.\textsuperscript{25} This decision allowed the State of Missouri to continue medical treatments which kept Nancy Cruzan "alive" because Nancy’s statements to her roommate were not considered to be clear and convincing evidence of her wishes.\textsuperscript{26} An interesting comment is made in the concurrence by Justice O’Connor where she strongly recommends the use of a DPAHC or a Living Will as a safeguard to the patient’s interest in directing their medical care. This comment by Justice O’Connor illustrates the importance of having an advance directive in order to avoid undergoing this level of scrutiny by the courts into extremely personal matters.

On December 14, 1990, in the case of \textit{Cruzan v. Mouton},\textsuperscript{27} the Jasper County Probate Court ruled that the parents of Nancy Cruzan had presented the requisite clear and convincing evidence, required by the State of Missouri, that their daughter would not want to continue in her present existence.\textsuperscript{28} The Jasper County Probate Court authorized the removal of her nutrition and hydration and on December 26, 1990, nearly eight years after her fatal car accident, Nancy Cruzan was put to rest.

A subsequent case decided in the State of Missouri, \textit{In re Busalacchi}\textsuperscript{29} is strikingly similar to the \textit{Cruzan} case.\textsuperscript{30} In \textit{Busalacchi}, state officials in Missouri blocked Pete Busalacchi from moving his daughter, who was in a persistent vegetative state, to another state in order to remove her feeding tube.\textsuperscript{31} At the request of the State’s attorney general, the Missouri Supreme Court dismissed the case, without an opinion, on the ground that the State should not intrude into private family matters.\textsuperscript{32} The effect of the dismissal changed the state’s

\textsuperscript{24}\textit{Id.} at 427.

\textsuperscript{25}497 U.S. at 261.

\textsuperscript{26}\textit{Id.}

\textsuperscript{27}Case No. CV384-9P, Jasper County Circuit (Missouri), Probate Division at Carthage (Dec. 14, 1990).

\textsuperscript{28}The court decided that Nancy’s conversation with a roommate in which she stated that she would not want to live unless she was at least "halfway normal" was considered to be clear and convincing evidence of Nancy’s wishes.

\textsuperscript{29}No. 73677, 1991 Mo. LEXIS 107 (October 16, 1991).

\textsuperscript{30}The cases are different in that Christine Busalacchi, a high school junior at the time of the accident had never discussed health care options with anyone, but Nancy Cruzan, a 30 year old female, had voiced her wishes regarding life-prolonging treatment.

\textsuperscript{31}No. 59582, 1991 Mo. App. LEXIS 315, at *1 (March 5, 1991).

\textsuperscript{32}No. 73677, 1991 Mo. LEXIS 107.
common law policy to allow family members to make decisions regarding health care, where a person is in a persistent vegetative state, and their health care wishes have not been previously declared. The Busalacchi case broadened the scope of patient self-determination in the State of Missouri.

B. Ohio Case Law

One of the first decisions in Ohio case law regarding the termination of life support was Leach v. Akron General Medical Center. In Leach, the patient, a seventy year-old woman, suffered cardiac arrest on July 27, 1980, and was placed on life support at which time her doctors indicated that she was in a chronic vegetative state. On October 21, 1980, her husband requested removal of her respirator. The doctors refused his request, and the husband brought the action. The court appointed the husband as guardian and also appointed a separate guardian ad litem to represent Mrs. Leach's interests. At an evidentiary hearing, seventeen witnesses testified that the patient's medical preference was to not be put on life-support. The court concluded that an individual's constitutional right to privacy guarantees to an incurable, terminally ill person in a persistent vegetative state the right to decide future medical treatment. The court granted the husband's motion to terminate the respirator, and on January 6, 1981, Mrs. Leach was removed from her respirator and died.

In the subsequent related case of Estate of Leach v. Shapiro, the representative of decedent's estate sought damages for the time period in which Mrs. Leach was on life support until the court determined that it could be withdrawn. The court dismissed the action stating that since the initial use of life support was properly authorized, no damages would be awarded for the time it took to secure court authority to terminate life support.

In Couture v. Couture, the court denied termination of nutrition and hydration of a patient in a persistent vegetative state who had not executed a DPAHC. The patient had previously clearly expressed his intentions, but under the DPAHC prior to revision, nutrition and hydration could only be withdrawn if death was "imminent". The court concluded that a time period of more than

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34426 N.E.2d 809 (Ohio 1980).

35 Id. at 815.

36469 N.E.2d 1047 (Ohio 1984).

37 Id. at 1052.

38549 N.E.2d 571 (Ohio 1989).

39See supra note 8.
one or two months was not imminent, implying that a period of less than one or two months would be construed as imminent.\textsuperscript{40}

The case of \textit{Couture} is overruled in Section 5 of Senate Bill 1 which provides that it is not the intent of the General Assembly to affect the ability of guardians of incompetents to make informed health care decisions for their wards. Further, if this case had been analyzed under the standards as set forth in Senate Bill 1, since Couture did not have an advance directive, he would have had to remain in a persistent vegetative state for twelve months before his guardian could request approval from the probate court to withdraw artificial nutrition and hydration.\textsuperscript{41}

Two important cases have been decided since the enactment of Senate Bill 1. One of the most recent issues to surface was detailed in the case of \textit{Anderson v. St. Francis/St. George Hospital Inc.},\textsuperscript{42} which decided the issue of "wrongful life". The patient was an eighty-two year-old male who had specified a Do Not Resuscitate order (hereinafter "DNR"), upon admission to the hospital.\textsuperscript{43} Notwithstanding the DNR order, the patient was resuscitated by a nurse and on the following day again stated that he did not wish to be resuscitated. He then suffered a stroke and was moved to a nursing home where he died twenty-two months later.\textsuperscript{44} The estate sued the hospital under a wrongful life claim stating the decedent's DNR order was not followed. The court held that no cause of action for "wrongful living" would be recognized in Ohio.\textsuperscript{45}

In the case of \textit{In re Guardianship of Myers},\textsuperscript{46} the patient, Carla Myers, was a minor female\textsuperscript{47} who suffered severe head injuries as a result of an automobile accident on October 25, 1992.\textsuperscript{48} The preliminary diagnosis indicated that Carla was in a comatose state and was receiving artificially administered nutrition and hydration.\textsuperscript{49} On December 2, 1992, Carla's father, Timothy Myers,
requested that nutrition and hydration be removed, but on December 7, 1992, Carla's mother, Robin Myers,50 requested that the nutrition and hydration be restored. Both parents then made an independent application to the court for appointment as Carla's guardian. At a hearing held on December 30, 1992, both Timothy and Robin Myers agreed to the appointment of an independent third party as the legal guardian of Carla for the purpose of making recommendations to the court concerning future medical decisions.51

On January 15, 1993, the legal guardian submitted a written report containing her recommendations and on January 20, 1993 a hearing was held to determine if the recommendations would be approved by the court.52 The report, as well as testimony from two neurologists and one doctor of internal medicine all concurred that Carla was in a persistent vegetative state and nutrition and hydration should be discontinued.53 The court then posed questions to Timothy Myers, Robin Myers and Penny Myers (Carla's stepmother), and all stated that they were in support of the removal of the procedures named.54

The court, in reviewing prior case law, found that there was not a criminal or civil violation for the removal of nutrition and hydration from an adult or a minor in a persistent vegetative state.55 The court did determine however, that two procedural problems existed, namely whether R.C. Chapter 2133.56 must be followed in this case and whether the substituted judgment test or the best interest test should be applied.57

The court indicated that Section 2133.09(B)(2) which sets forth the requirement that twelve months must elapse from the inception of the persistent vegetative state before nutrition and hydration may be removed from a nondeclarant, under the circumstances of the case, would serve no purpose and would be unreasonable.58 The court declared that "R.C. 1.47(C) states that when interpreting legislation, it must be assumed that 'a just and reasonable result is intended.'"59 The court found that applying the provisions

50Timothy Myers and Robin Myers, the natural parents of Carla Myers were divorced at the time of this proceeding.

51610 N.E.2d at 664.

52Id.

53Id.

54Id. at 665.

55Id. at 667-68.

56R.C. Chapter 2133 is the living will statute. See infra notes 93 through 98.

57610 N.E.2d at 668.

58Id.

59Id.
of Section 2133 to all life support removal cases was "neither reasonable nor within the plain meaning of the statute."\(^6\) The court held that Section 2133 was not binding in this case and would bring about an unreasonable result.\(^6\) This case undoubtedly will set a precedence in the state for discounting the statute where it suits the result desired in a case.

The second procedural question was whether the substituted judgment test or the best interest test should be applied to this case. The court determined that the best interest test has been the historic guardianship standard and that statute mandates use of this test in all medical decisions for a ward, including life-sustaining treatment cases.\(^6\) Consequently, in applying this standard, the court found that removal of life-sustaining treatment would be in the best interest of Carla.\(^6\) The court concluded by saying "[t]he benefits and arguments are overwhelmingly in favor of removal. It is time to remove the invasive and futile medical technology. It is time to let Carla die."\(^6\)

Carla Myers' nutrition and hydration were removed on February 1, 1993, and she died on February 8, 1993.\(^6\)

The cases discussed above from both Ohio and other jurisdictions formed the basis for drafting and passing Senate Bill 1. Using the decisions from these common law court decisions, the legislature along with representatives from both the Ohio State Bar Association (hereinafter "OSBA") and the Ohio State Medical Association (hereinafter "OSMA") formed the framework for executing both a Living Will and a Durable Power of Attorney for Health Care.

III. LEGISLATIVE HISTORY AND GENERAL PROVISIONS OF SENATE BILL 1

A. Legislative History

On January 22, 1991, Ohio State Republican Senator Betty Montgomery introduced Senate Bill 1 on the floor of the Senate.\(^6\) The Bill was the product of legislative history of the passage of Am. Sub. Senate Bill No. 1:

- 1/22/91 Bill introduced by Ohio State Republican Senator Betty Montgomery.
- 1/30/91 To Senate Committee on Reference and Oversight.
- 2/05/91 From Senate Committee on Reference and Oversight which recommended as substituted.
- 2/05/91 Bill Passes the Senate, to the House of Representatives.
- 2/14/91 To House Committee on Civil and Commercial Law.
- 6/18/91 From House Committee on Civil and Commercial Law which recommended as substituted.
of a joint working group created in 1990 by the OSBA and the OSMA. The general intent of the Bill was to create statutory regulations which clarified the DPAHC provisions currently in effect, and to provide Ohioans with the opportunity to execute a living will declaration, which would be a legally recognizable document by the State. Senate Bill 1 was favorably reviewed by the Senate on February 5, 1991, and then went on to the House of Representatives where, after numerous hearings and drafting sessions, the Bill was passed on June 20, 1991. The Senate concurred with the amended House Bill on June 25, 1991. The final version of the Bill went to Governor George V. Voinovich on July 3, 1991 and was signed into law on July 11, 1991, with an effective date of October 10, 1991.

B. General Provisions of Senate Bill 1

Senate Bill 1 makes provisions for executing a DPAHC and a Living Will and it also addresses procedures to follow if no advance directive has been executed. The legislature intended that advance directives be used to open up the lines of communication between patients, family members and health care providers on this difficult subject.

Many people, including some health care providers, have a false perception that an advance directive is not merely a choice of treatment but a refusal of treatment. In fact, there have been reported incidents where an advance directive was assumed to be a Do Not Resuscitate Order without ever reading the instructions contained in the document. Although an advance directive can be used to specify that your medical preferences are to not continue

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tr>
<td>6/20/91</td>
<td>Bill amended on House floor. Passed the House, to Senate for concurrence.</td>
</tr>
<tr>
<td>6/25/91</td>
<td>Senate concurred in House Amendments.</td>
</tr>
<tr>
<td>7/03/91</td>
<td>To Governor George V. Voinovich for signature.</td>
</tr>
<tr>
<td>7/11/91</td>
<td>Signed into law by Governor Voinovich.</td>
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The joint working group addressed three basic issues: (1) revisions in the Durable Power of Attorney Law created by Am. Sub. S.B. 13; (2) adoption of a Living Will Declaration in Ohio; and (3) rules for obtaining consent for incapacitated persons who have not executed an advance directive. See William M. Todd, *Directing Health-Care Choices*, 5 OHIO LAW. 10 (1991).

68See supra note 66.

69See supra note 66.

70This article is not meant to provide an in-depth review of the definitions, technical requirements and court procedures with regard to advance directives, but merely a general overview of advance directives and definitions of some of the more important terminology contained in Senate Bill 1. For a more thorough analysis see Todd, *supra* note 67.


life-prolonging measures under certain circumstances, your documents may also direct that care be continued, and not terminated.73

1. Durable Power of Attorney for Health Care

A DPAHC is a document which allows a principal74 to designate an attorney-in-fact75 to make health care decisions on his or her behalf in the event that he or she becomes incapacitated. The determination of whether the principal is incapacitated can only be made by his or her attending physician.76 The DPAHC does not become effective until the principal has lost the ability to make informed health care decisions for himself or herself.77

Once a DPAHC becomes effective it remains in effect until the document is revoked78 or upon a date specified in the document.79 If the principal is incapacitated at the time the document is set to expire, it will continue in effect until the principal again regains capacity.80 The principal's ability to revoke a DPAHC has been greatly enhanced under Senate Bill 1.81 In the prior DPAHC statute, the principal was limited as to how revocation must take place in order for it to be an effective revocation.

The DPAHC, when in force, can create broad powers in the attorney-in-fact to make health care decisions for the principal, or it can limit such powers, depending upon the principal's wishes. There are however certain statutory limitations which cannot be overridden by the DPAHC. The most important


74 A principal is defined as any competent adult who is eighteen years or older. § 1337.11(A).

75 An attorney-in-fact can be any competent adult except (i) the principal's attending physician or an employee or agent of the attending physician; (ii) an administrator of a nursing home in which the principal is receiving care; or (iii) an employee or agent of any health care facility in which the principal is being treated. § 1337.12(A)(2). These limitations do not apply if the attorney-in-fact is related to the principal by blood, marriage or adoption, or is a member of the same religious order as the principal. §§ 1337.12(A)(2).

76 § 1337.11(B) defines an attending physician to be "the physician to whom a principal or his family has assigned primary responsibility for the treatment or care of the principal or, if the principal or his family has not assigned that responsibility the physician who has accepted that responsibility."

77 § 1337.12(A)(1).

78 § 1337.12(A)(3).

79 Id.

80 Id.

81 § 1337.14(A) states in part that "[T]he principal may so revoke at any time and in any manner."
of these limitations are as follows: (1) the attorney-in-fact may only withdraw or refuse to consent to life-sustaining treatment\(^2\) if the principal is in a terminal condition or in a permanently unconscious state and the attending physician has determined that there is no reasonable possibility that the principal will ever regain decision-making capacity; and physician is so qualified to make such a determination;\(^3\) (2) the attorney-in-fact cannot direct the withdrawal of comfort care;\(^4\) (3) the attorney-in-fact generally cannot direct the withdrawal of life-sustaining treatment from a pregnant principal "if the refusal or withdrawal of health care would terminate the pregnancy," unless the attending physician and at least one other physician determine that the pregnancy will pose a substantial risk to the principal's life or that it is reasonably certain that the fetus would not be born alive;\(^5\) (4) the attorney-in-fact cannot direct the withdrawal of nutrition and hydration unless the principal is in a terminal condition or a permanently unconscious state, two physicians agree that nutrition and hydration will no longer provide comfort or alleviate pain of the principal, and in the case of a principal in a permanently unconscious state, the express statutory authorization is contained in the DPAHC;\(^6\) and (5) the attorney-in-fact may withdraw health care that was previously consented to by the principal only if "[a] change in the physical condition of the principal has significantly decreased the benefit of that health care to the principal" or "[t]he health care is not, or is no longer significantly effective in achieving the purposes for which the principal consented to its use."\(^7\)

The revised DPAHC now imposes certain obligations upon the attending physician to make a good faith effort to notify certain individuals before withholding life-sustaining treatment.\(^8\) In addition, the attending physician must record the proceedings in the patient's medical records.\(^9\) Any of the individuals notified may, within forty-eight hours of receiving the notice, object

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\(^2\)Life-sustaining treatment is defined as "any medical procedure, treatment, intervention, or other measure that, when administered to a principal, will serve principally to prolong the process of dying." § 1337.11(P).

\(^3\)§ 1337.13(B).

\(^4\)§ 1337.13(C). Comfort Care is defined in § 1337.11(C) and "means any of the following: (1) nutrition when administered to diminish the pain or discomfort of a principal, not to postpone his death; (2) hydration when administered to diminish the pain or discomfort of a principal, not to postpone his death; [and] (3) any other medical or nursing procedure, treatment, intervention, or other measure that is taken to diminish the pain or discomfort of a principal, not to postpone his death."

\(^5\)§ 1337.13(D).

\(^6\)§ 1337.13(E).

\(^7\)§ 1337.13(F).

\(^8\)§ 1337.16(D)(1)(B) indicates in order of descending priority the individuals which the attending physician must notify.

\(^9\)§ 1337.16(D)(1)(A).
to the withholding of such treatment by communicating their objections to the attending physician. The objecting individual must then file a complaint in the probate court having jurisdiction, within two business days after communicating the objection to the attending physician. The statute provides for the manner of stating objections and for the granting of relief by the court.

2. The Living Will Declaration

The Declaration provisions contained in Senate Bill 1 provide for any competent adult to declare his or her intentions regarding health care in the event of the individual’s incapacity. The Declaration is more commonly known as a “Living Will”. The provisions contained in Senate Bill 1 regarding the living will are substantially similar to the provisions for the DPAHC. The significant differences between the living will and the DPAHC are: (1) the living will does not make any provisions for an attorney-in-fact, the instructions contained in a living will declaration are communicated directly to the declarant’s attending physician; and (2) the living will declaration is only applicable when the declarant is in a terminal condition or in a permanently unconscious state, whereas the DPAHC is applicable to any period of incapacity suffered by the declarant. In the event that you are incapacitated, but are not in a terminal condition, the DPAHC would be effective, however a living will declaration would not. For this reason, it is advisable to execute both a living will declaration and a DPAHC. Executing both documents provides solutions for many of the medical problems that could arise where you are incapacitated and need an attorney-in-fact to declare your intentions regarding health care.

In executing a Living Will, Ohio takes its execution requirements to the extreme, for instance, requiring that in order to be valid, provisions pertaining to nutrition and hydration be in capital letters and initialed in the margins.

A living will declaration becomes operative when the attending physician and one other physician determine that the declarant is either in a terminal condition or permanently unconscious state and the attending physician determines that the declarant can no longer make informed decisions regarding the administering of life-sustaining treatment. In addition, the attending physician must determine that there is no reasonable possibility the declarant will regain the capacity to make informed decisions regarding health care.

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90§ 1337.16(D)(3).
91Id.
92§ 1337.16(D)(4).
93See supra note 3.
94See supra notes 74 through 92 and accompanying text.
95§ 2133.02(A)(3)(a)(I).
96§ 2133.03(A)(1).
treatment. Although the statutory definitions and terminology are substantially similar for living will declarations and the DPAHC, Senate Bill 1 provides that a living will declaration supersedes a DPAHC if the issue in conflict relates to life-sustaining treatment.

3. Health Care Decisions for Nondeclarants

Senate Bill 1 makes provisions for permitting the termination of life-sustaining treatment when no advance directive has been executed. The family may request termination of treatment when the patient is in a terminal condition or a permanently unconscious state; however the family’s decision must be consistent with the patient’s previously expressed wishes, or, if none were expressed, then what the patient would have decided "as inferred from the lifestyle and character of the patient." The request must be witnessed by two qualified individuals and must be executed by the individual with the proper authority as indicated by the priority list established by statute. In the case of a terminal patient, the attending physician and one other physician must determine that the patient is in a terminal condition and there is no reasonable possibility that the patient will regain the capacity to make informed decisions. If the patient is in a permanently unconscious state there must be certification that the patient has been in that condition for at least twelve months before life-support can be terminated. It is my opinion that the twelve month period is too long a period of time to apply to every situation, and as indicated by the opinion in the case of In re Guardianship of Myers discussed above, at least one court agrees. Further, only the probate court in the county in which the patient is located (and not merely the family and physicians) may order the discontinuance of nutrition and hydration.


Senate Bill 1 creates immunity from criminal liability for a patient’s physicians and health care facility when decisions are made in good faith and

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97§ 2133.03(A)(3).
98§ 2133.03(B)(2).
99§ 2133.08(B).
100§ 2133.08(D)(2).
101§ 2133.08(D)(3).
102§ 2133.02(B)(1) sets forth the criteria for being a qualified witness.
103§ 2133.08(B).
104§ 2133.08(A)(1)(A).
105Id.
106§ 2133.09(C)(1).
in reliance on a valid living will, or what is believed to be a valid living will.\textsuperscript{107} Immunity also exists where a physician or a health care facility fails to comply with a living will or a consent order in a nondeclarant situation.\textsuperscript{108} This provision is an important safeguard for care givers in that they are not held liable for performing unwanted medical procedures.\textsuperscript{109} The one major exception to the immunity provisions is where an individual's actions are outside of the scope of their authority.\textsuperscript{110}

A related issue to the immunity provisions is the transfer provisions which provide for a health care facility or a physician to transfer the patient to a different physician or health care facility when the physician or facility are unwilling or unable to comply with the directions of the attorney-in-fact.\textsuperscript{111} This safeguard measure protects not only the physicians and the health care facility, but also allows the patient's wishes to be carried out when there is a conflict due to religious or other reasons.

With regard to reciprocity of other state's advance directive forms, if the forms substantially comply with Ohio law, the declaration will be considered valid.\textsuperscript{112} Declarations that were executed prior to enactment of Senate Bill 1 will be considered valid as long as they describe terminal condition and permanently unconscious state, two of the principal definitions in Senate Bill 1.\textsuperscript{113} If there is any doubt as to the validity of an advance directive executed prior to October 10, 1991, it would be advisable to execute new documents which reflect the provisions of Senate Bill 1. Further, if the declaration does not contain the specific statutory provisions relating to the withdrawal of nutrition and hydration, the declaration will not be applicable for withdrawal of those treatments, and the patient will be treated as a nondeclarant.\textsuperscript{114}

IV. INTERACTION OF SENATE BILL 1 WITH THE FEDERAL PATIENT SELF-DETERMINATION ACT

A. Background of the Patient Self-Determination Act

The Federal Patient Self-Determination Act (hereinafter "PSDA") was enacted by Congress as part of the Omnibus Budget Reconciliation Act of

\textsuperscript{107}\$ 2133.11(A).
\textsuperscript{108}\$ 2133.11(A)(4).
\textsuperscript{109}This provision, however, is not a step forward from the point of view of patient autonomy.
\textsuperscript{110}\$ 2133.11(D).
\textsuperscript{111}\$ 1337.16(B)(2).
\textsuperscript{112}\$ 2133.14.
\textsuperscript{113}\$ 2133.15(A).
\textsuperscript{114}\$ 2133.15(B).
1990. The PSDA requires that virtually all health care facilities develop a program for discussing advance directives for health care which are available under the applicable state's law, with all patients who will be receiving services at that facility as an in-patient. The patient must be advised of the law at the time the service at the facility begins. Generally, this has been accomplished during the admission process. A health care facility has been defined to include hospitals, nursing homes, hospices and providers of home health care.

The PSDA requires all Medicare and Medicaid provider organizations to "(1) provide written information to patients concerning their health care decision making rights; (2) provide written information to patients concerning the organizations implementation of such rights; (3) document in the patient’s medical record whether the patient has executed an advance directive; (4) ensure compliance with the requirements of state law respecting advance directives; and (5) provide for education of their staffs and the community concerning advance directives."

B. Interaction of Senate Bill 1 with the Patient Self-Determination Act

The PSDA and Senate Bill 1 are inextricable from one another with each providing specific information concerning implementation of advance directives law. As illustrated in the prior section, the PSDA is the federal law which requires health care providers to inform patients of their health care decision making rights under the applicable state law. The state law, in turn, provides details of what those decisions indicate with regard to either continuation or withholding of medical treatment.

It is important that the health care providers explain the law in such a way as to allow the patient to make informed health care choices which reflect a thoughtful decision. Further, the ramifications of not having an advance directive should also be reviewed and explained in order to fully advise the patient of all potential scenarios. In order to assist in providing uniform information to patients, the Ohio Department of Human Services has prepared a pamphlet entitled "You Have The Right" which provides information concerning advance directives. The pamphlet gives a general overview of

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116The statutory requirements are contained in 42 U.S.C. 1395cc(a)(1), § 4206, Medicare Provider Agreements Assuring the Implementation of a Patient's Right to Participate in and Direct Health Care Decisions Affecting the Patient; and 42 U.S.C. 1396a(a), § 4751, Requirements for Advanced [sic] Directives Under State Plans for Medical Assistance.

11742 U.S.C. 1395cc(f).

118Id.

119This pamphlet was obtained at a conference on Ohio's Advance Directives Law and the PSDA, held on February 5, 1993 in Cleveland, Ohio, sponsored by the Center for Biomedical Ethics, Case Western Reserve University, Cleveland, Ohio.
what a patient's choices are regarding advance directives by listing frequently
asked questions and their answers. Some health care facilities include this
pamphlet with their patient information packet which patients receive upon
admission.\textsuperscript{120}

C. Have the Goals of the PSDA and Senate Bill 1 Been Attained?

One of the goals of the PSDA was to promote the execution of advance
directives in order to reflect the patient's values and beliefs with regard to
medical treatment.\textsuperscript{121} The increased use of advance directives is anticipated by
some to reduce health care costs as the use of life-prolonging treatments would
decrease.\textsuperscript{122} However, since the PSDA's inception in 1991, the number of
advance directives being completed has not increased and health care costs
have not decreased.\textsuperscript{123}

Although there has been increased awareness by individuals as a direct
result of the PSDA, there is still a significant reluctance by healthy individuals
to execute a document that directs end-of-life decisions.\textsuperscript{124} When compared
with the fact that usually only 50\% of the population executes a Last Will and
Testament directing their property, it is not surprising that only an estimated
30\% of the people, who are aware of the new legislation, will execute an
advance directive.\textsuperscript{125}

Another goal of the new legislation was to provide patients with the
appropriate information in order to compel patients to actively participate in
their own health care decision making. According to the new regulations as set
forth in the PSDA, the majority of information is being disseminated to
individuals at health care facilities. A standard observation (and complaint)
regarding the requirement of the PSDA that health care facilities provide
patients with advance directive information, is that the forms are given to the
patients during the admissions process.\textsuperscript{126} During this procedure the patient
receives a multitude of forms and written material regarding such subjects as

\textsuperscript{120}This information was obtained by taking an informal survey of the health-care
representatives in attendance at the Advance Directives Seminar identified in note 119,
supra.

\textsuperscript{121}Gregory S. French, The Patient Self-Determination Act: Patients Need to Be Informed of

\textsuperscript{122}This assumption is based upon the premise that the majority of advance directives
request discontinuance of treatment and not additional life-prolonging measures, which
would increase costs and thus make this statement invalid.

\textsuperscript{123}Cotton, supra note 72.

\textsuperscript{124}This comment is the result of observing estate planning clients and their habits
over the past several years while working as a legal assistant in the estate planning field
at a large midwest law firm.

\textsuperscript{125}French, supra note 121.

\textsuperscript{126}John La Puma, et. al., Advance Directives on Admission, Clinical Implications and
hospital policies and insurance regulations and the advance directives seem to get "lost in the shuffle". Further, the requisite communications between the health care provider (who in many cases is merely the admission's clerk) and the patient may consist of merely asking if the patient has executed an advance directive, with no further dialogue after the patient's yes or no response. This lack of follow-up by the health care facility needs to be addressed so that patients receive the proper information in order to make informed health care choices. Due to the newness of the laws, no definitive studies have been conducted regarding the effect of Senate Bill 1 and the PSDA, consequently, it is too early to decide if the goals of the PSDA and Senate Bill 1 have been achieved.

V. EFFECT OF SENATE BILL 1 AND THE PATIENT SELF-DETERMINATION ACT ON HEALTH CARE PROVIDERS

A. Two Divergent Viewpoints on the Implementation of Senate Bill 1 and the PSDA

In any analysis of a subject matter, there is always a grey area, and a group of people who don't fall neatly into either one of the boxes representing the diverse viewpoints. I am not concerned here with this grey area but with these diametrically opposed viewpoints which will illustrate the wide range of opinions on these new laws and where the problems have arisen during the period since enactment.

The first viewpoint is of those individuals who vehemently oppose the requirements of the new laws (both state and federal) and what changes they believe would make the legislation more effective. The second viewpoint represents the proponents of the bill and the positive results and changes that have come about since its enactment.

1. Negative View of Senate Bill 1 and the PSDA

In the State of Ohio, the PSDA's requirement that health care facilities discuss Senate Bill 1 with patients and their families is viewed by many as an enormous burden on these facilities. The requirement forces the health care facilities to

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127 Cotton, supra note 72.

128 Cotton, supra note 72.


130 A small-scale, informal study was conducted by the researchers from the Department of Veterans Affairs, the Robert Wood Johnson Clinical Scholars Program and the University of California, and the findings were that the instructions given in an advance directive did not always reflect the patient's actual wishes. See, Sehgal, et. al., How Strictly Do Dialysis Patients Want Their Advance Directives Followed?, 267 JAMA 59-63 (1992).

131 Although the argument is put forth that an enormous burden has been put upon the health-care providers, I would argue that after the initial expense of training
educate not only their employees, but also individuals who are requesting services from their organization. This burden and, in fact, the entire premise of Senate Bill 1 does not meet with the approval of some individuals. These individuals believe that Senate Bill 1 needs to be completely overhauled in order to be successfully implemented and interpreted by both health care providers and the general public. Senate Bill 1 has also been attacked as being "lengthy, confusing and restrictive of the rights of patients and families." In support of this proposition, a commentary was rendered in comparing the Illinois Health Care Surrogate Act, which was passed two weeks prior to the passage of Senate Bill 1, with the provisions contained in Senate Bill 1. The commentary stated in part: "Considering they were drafted in the same time frame, it's striking how different they are from one another in time, style and orientation...Ohio's law, facetiously referred to as the "full-employment for attorney's act" is cumbersome (over 60 pages) and unduly complicated." One individual stated that "[T]he current version of S.B. 1 forces lawyers to act like doctors and doctors to act like lawyers. It is supposed to be the other way around." In defense of Senate Bill 1, William M. Todd, one of the initial drafters and a proponent of Senate Bill 1 warned that any "tinkering" with the new law could backfire and stated that "[I]f we go back to the legislature now, there's no control over what will happen.

Additional barriers to successful implementation of Senate Bill 1 exist in several different areas. One view is that there are three basic barriers to successful implementation of the PSDA: (1) clinical barriers; (2) legal barriers; and (3) ethical barriers.

personnel to comply with the act, the actual time and expense involved should be quite minimal. Further, I would challenge this group of individuals to propose an alternative industry which would be more appropriate to handle this requirement.

132Paul A. Greve, Jr., S.B. 1: A Hospital Attorney's Perspective, 3 HEALTH L.J. OF OHIO 145 (May/June 1992). In Mr. Greve's article he states that "I have spent 20 years employed by hospitals, and I believe that S.B. 1 is the most troubling legislation of a career." Id. at 145.

133See Greve, supra note 132.

134See Greve, supra note 132 at 145.


136See Greve, supra note 132 at 150. The Greve article provides a thorough review, section by section, of the problems and complaints of Senate Bill 1. In addition, it provides some helpful suggestions on how the Bill should be amended in order to make it more effective.

137Laura Yee, Health Care Workers Struggle With Law, THE CLEVELAND PLAIN DEALER, February 6, 1993, at 1D.

138For a detailed analysis of the barriers to successful implementations of the PSDA, see, La Puma, supra note 126.

139See La Puma, supra note 126 at 403-04.
Clinical barriers exist because of the improper procedures used by health care facilities in providing the proper information, at the appropriate time, to patients. If the information is not provided in a manner that is clearly understood, the patients may "make choices that are neither voluntary nor reasoned but borne out of the immediacy of their pain, discomfort, fears and the press of time."\textsuperscript{140} Reviewing choices during this vulnerable time is a difficult task, and a patient's thinking may not be clearly focused on what choices would be the most appropriate for their situation. Further, some doctors and nurses have stated that when the family members and the physician have reached a consensus they have not been following the requisite waiting period required in certain circumstances under Senate Bill 1.\textsuperscript{141} This situation can be very dangerous as an unwarranted precedent could be established at certain hospitals, instead of following the precise language of the statute.

Legal barriers exist for the reason that the statute imposes a minimal standard of behavior, which in most instances is the maximum standard adopted by the health care facilities.\textsuperscript{142} In order not to contradict the provisions of the PSDA and Senate Bill 1, the health care facilities will only implement the procedures as specifically set forth in the statute, thus avoiding any potential conflicts. This minimal standard may be significantly less than what the health care facility would have implemented without the statutory guidelines.

Ethical barriers exist because of cost containment issues that arise when dealing with Medicare patients.\textsuperscript{143} The use of advance directives by elderly patients is eventually expected to decrease Medicare costs as more patients opt to limit end-of-life medical treatment which in most cases is extremely expensive.\textsuperscript{144} The use of advance directives to achieve cost containment is highly unethical and every effort must be made to discourage and reprimand institutions who influence patient's decisions purely for financial gain.

The complaints of health care providers and other professionals may be valid, but it is important to remember that the purpose and intent of Senate Bill 1 and the PSDA was to provide a framework for executing advance directives, and to open up the lines of communication between patients and doctors regarding this subject.

\textsuperscript{140}La Puma, \textit{supra} note 126 at 403.

\textsuperscript{141}See, Yee, \textit{supra} note 137.

\textsuperscript{142}See La Puma, \textit{supra} note 126 at 404.

\textsuperscript{143}La Puma, \textit{supra} note 126 at 404.

\textsuperscript{144}Many end-of-life treatments consist of costly medical treatments which are both expensive to operate and expensive with regard to the medical personnel required to operate them.
2. Positive View of Senate Bill 1 and the PSDA

Although the initial objectives of the PSDA may not as yet been reached, there are some positive aspects to its enactment. First, with this kind of legislation where patient awareness is tantamount to successful implementation, any form of information is a step in the right direction. The more information the individual receives, from whatever source, the more likely it will be that compliance will eventually be achieved. In addition, implementation of the PSDA provides added assurances for both physicians and patients that end-of-life health care decisions have been made and will be honored. Individuals can be assured that since they have expressed their medical preferences, that in the event they are incapacitated, conflicts between family members may potentially be avoided. Physicians can feel more at ease in their care and treatment of patients when they are expressly following the patient’s wishes. The advance directive takes some of the guesswork out of health care and allows the physician to do what he does best, practice medicine.

B. Clinical Observations of the Effect of Senate Bill 1 and the PSDA on Patients

Several interviews were conducted with the staff members of a suburban northeastern Ohio hospital to discuss their personal experiences in implementing the requirements of the PSDA and Senate Bill 1. The goal of the interviews was to determine the procedures, perceived problems, and patient responses and attitudes, both positive and negative, to the PSDA and Senate Bill 1.

The following is an overview of the information obtained during the course of the interviews. First, the procedural aspects, as required by the PSDA, were discussed. The procedure at this facility, (which I was informed was similar to the procedure of the majority of the health care facilities), was to obtain information from the patient during the admissions process. The patients were asked: "Do you currently have an advance directive?" The response is entered into the computer, and if the patient has an advance directive, a copy is requested and placed in the patient’s file. The admissions clerk indicated that each situation is handled differently depending upon the patient’s response to the initial question, but that typically if the patient did not have an advance directive, an information packet would be provided to them. In addition, social workers were referred to the patients for follow-up and to answer any questions.

The hospital indicated that only about 5% of the patients being admitted have an advance directive in place. These 5% consist mainly of older couples

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145 In order to elicit more candid responses from the interviewees, it was agreed that their names and the name of their employer would remain anonymous.

146 The staff did not know what happened to it after that point, or if anyone actually read or discussed it with the patient.

147 The information packet contains a pamphlet which explains the current law in Ohio, a copy of a living will and a copy of a durable power of attorney for health care.
who are well connected in the community, and widows or widowers who had
gone through a serious illness with a spouse. Overall, they indicated that the
response from the patients was positive, although it was determined that the
majority of the patients did not address the issue of an advance directive until
well after they were discharged from the hospital. Frequently, individuals
would contact the social worker whom they were initially referred to, to discuss
the information they received while in the hospital. Many indicated that they
just did not want to deal with the issue while they were in the hospital, but did
want to receive more information now that they had time to think about their
decisions.

A surprising number of inquiries came from unsolicited requests from
members of the community who made cold calls to the hospital requesting
information about advance directives. The hospital’s procedure is to send out
their initial patient admission packet to these individuals. The hospital staff felt
that it was their responsibility to disseminate information to the community,
and they frequently go out as a team to local nursing homes and elder care
centers to give lectures on the subject of advance directives.

Although community education is a high priority, they also indicated that it
was the education of the staff members that was the most important. If the staff
is comfortable with advance directives and their purpose, and if they exhibit a
comfort level with the information, that confidence will be transferred to the
individuals they are in contact with.

Overall, the hospital staff found that the requirements of the PSDA were
more burdensome in writing then they were in actual application. They also
discovered that by discussing the details of an advance directive, the law
actually opened up a door for them to discuss various potential problems and
health care issues with patients, through the options available in an advance
directive.

VI. PUBLIC EDUCATION

Despite the educational campaigns sponsored by both the Ohio State
Medical Association (hereinafter "OSMA"), and the Ohio State Bar Association
(hereinafter "OSBA") plus the substantial efforts of various other governmental
organizations such as the Ohio Department of Human Services and the Ohio
Department of Aging, most people are still either unaware of or confused by
the advance directives that are available to them. Educational efforts by all
organizations are continuing with the optimistic view that eventually
compliance with both the PSDA and Senate Bill 1 will be achieved.148

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148 The Society for the Right to Die, located in New York City has published a
compilation of every living will and durable power of attorney for health care in the
United States. The loose-leaf binder, which will be updated periodically, entitled
"Refusal of Treatment Legislation" is available by contacting the Society for The Right
to Die at (212) 246-6973.
A. Plans For Disseminating Information

One of the details of the PSDA was to require a national public education campaign in order to inform the general public of their options regarding participation in and direction of health care decisions. Through the efforts of the Ohio State Medical Association and the Ohio State Bar Association, a joint campaign was implemented to provide information and forms to the general public. This information can be obtained through the OSBA and the OSMA as well as other organizations. The educational package from the OSBA consists of a 14 minute videotape highlighting the new law and provides answers to general questions about advance directives. The videotape is intended for use in client or patient situations to give general background information about advance directives. The videotape is not an in-depth look into Senate Bill 1, but it is a starting point for promoting communication between physicians and patients. One Ohio hospital is showing the video on their in-house patient education channel which also provides other useful information regarding the hospital’s policies and procedures. The educational package available from the OSBA also includes a speaker’s kit, consisting of several documents, which provides information for public speakers and for outlining uniform answers to the standard questions which patients may have. Finally, a small fact sheet produced by the OSBA entitled “What you Need to Know About Ohio’s Living Will Law” is included. The fact sheet is generally a repetition of the information contained on the videotape, but again is useful for general education and discussion purposes.

Standard Ohio Living Will and DPAHC forms are available from both the OSBA and the OSMA. These forms are the standard state mandated forms and should be used in lieu of a computer generated form. The use of the standard form will alleviate any questions as to whether all of the requirements of the advance directive as stated in Senate Bill 1 are contained in the document. Physicians and health care facilities in general are more comfortable in receiving the standard forms so that no additional review by legal departments is needed in order to discern if the document conforms to Ohio law.

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149 To receive a Living Will information kit, write to: OSBA Living Will Program, P.O. Box 16562, Columbus, Ohio 43216-6562. The cost of the kit is $15.00 for members of the OSBA and $30.00 for non-members. Information is also available through the Ohio State Medical Association, P.O. Box 931, Columbus, Ohio 43216-0931; the Ombudsmen’s office, 1-800-282-1206; and the Legal Headline for Older Ohioans at 1-800-488-6070.


151 To obtain a free living will form for any state, send a self-addressed, business-sized envelope to: Choice in Dying, Box Q, 250 W. 57th Street, New York, New York 10107.

152 See French, supra note 121.
B. What The Future Holds

In a continued effort to educate the public about the advance directive provisions contained in Senate Bill 1, the Ohio General Assembly has recently passed Substitute House Bill Number 427 (hereinafter "House Bill 427"). Although the majority of the sections of House Bill 427 took effect on October 18, 1992, the Bill contains two new Ohio Revised Code Sections regarding advance directives which did not take effect until May 1, 1993.153 The new code sections provide for a designation on an individual's driver's license of whether or not he has executed either a Durable Power of Attorney for Health Care or a Living Will Declaration. If the Applicant for a driver's license has executed either type of document, he may, if he wishes, indicate this on his driver's license. As this statute has recently taken effect, it is not yet known how this legislation will impact public awareness of advance directives.

This statute may be an effective way of communicating the advance directive choices which are available to Ohioans in Senate Bill 1. Considering the fact that the majority of Ohioans have a valid driver's license which needs to be renewed every four years, the potential to reach a substantial number of individuals could be achieved through this new legislation.154

VII. CONCLUSION

Senate Bill 1 is Ohio's first comprehensive statute which provides a legislative template for executing an advance directive. This legislation, although not yet perfected, and not yet embraced by all members of society, is a statute which was critically needed in this state.

Like any new legislation, the education and dissemination of information is a slow process which gradually accelerates as more of the mainstream population becomes aware of its existence. Even at the introduction of Senate Bill 1, proponents of the Bill knew that it wouldn't satisfy all of the individuals that it would affect. As early as October of 1991, the month that Senate Bill 1 took effect, William M. Todd, a drafter and proponent of the Bill stated that "Perhaps no one will be content with all of the provisions of Senate Bill 1, but these are not easy issues and in many cases there are no clear-cut answers."155

The process of educating the public has been put in motion, and although it would be optimistic at best to assume that the majority of individuals will execute an advance directive, the current numbers are still somewhat disappointing. Nevertheless, even if the original lofty goals of the PSDA and Senate Bill 1 have not yet been attained, the lines of communication have been opened, the requisite statutes are in place and with continued public awareness.

153§ 4507.06(A)(1)(f) and § 4507.13(A).
154A caveat to any high expectations is the reality that the organ donation program has not been a complete success.
155Todd, supra note 67 at 10.
through education, the goals may still be realized. Educating the public can plant the seed, but it cannot do it all. Follow-up and interaction with the public is necessary in order for the PSDA and Senate Bill 1 to be successfully implemented.

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156Lawrence J. Nelson, an attorney and bioethics consultant in Illinois states that How smoothly the implementation [of the PSDA] is going depends on the hospitals and hospital lawyers and the attitude toward the law... If they see it as a burdensome government regulation and they do the absolute minimum, it's not going to have the effect it could. But if they look at it in a positive way to communicate information so that patients can make up their own minds about treatments, to make it easier on everyone, implementation might be very smooth. Quoted in Terese Hudson, Hospitals Work to Provide Advance Directives Information, 65(3) HOSPITALS 26 at 32 (1991).