

Indiana's New Health Care Consent Act: A Guiding Light for the Health Care Provider

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I. INTRODUCTION

Many seriously ill patients are incapable of making health care decisions on their own behalf because such factors as trauma, disease, pain, medication or senility interfere, at least temporarily, with their ability to approve or disapprove a course of medical treatment. However, a patient does not lose his¹ common law and constitutional rights simply because he is stricken with a debilitating infirmity. Unless there is a medical emergency,² the physician must still obtain valid consent before treating the patient. Often, the patient has lapsed into unconsciousness without giving any prior instructions or other evidence of consent and the doctor must seek consent from someone else. Inevitably, the question arises as to who may give legal consent to treat the patient.³ Surprisingly,

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¹The author has elected to use the masculine pronouns "him" and "his" for ease in presentation rather than a more awkward form showing applicability to both sexes. No other purpose is intended.

²IND. CODE § 16-8-3-2 (1982).

³IND. CODE § 16-8-3-1(a) (Supp. 1986) (current version at IND. CODE §§ 16-8-12-1 to -12 (Supp. 1987)) stated:

(a) Consent to medical or surgical treatment of a person (referred to in this chapter as the "patient") incompetent to give such consent by reason of minority, medical incapacity, mental illness, mental retardation, senility, alcoholism, or addiction to narcotics or dangerous drugs may be given by the following persons, and such consent shall be binding on the patient and the patient's heirs, administrators, executors, and personal representatives:

(1) If the patient is an unmarried unemancipated minor:

(A) by one (1) parent having custody of such minor;

(B) if there is no custodial parent, by the legal guardian of the minor; and

(C) if the patient is a neglected child, by the agency of which the child has been made a ward of the juvenile court.

(2) If the patient is an emancipated minor, by the patient.

(3) If the patient is incompetent for a reason or reasons other than minority, and has been so adjudged by a court of competent jurisdiction, then by the legal guardian of the patient. If the patient has been committed to an appropriate facility, then by the superintendent of such facility in accordance with the procedures in section 3[16-8-3-3] of this chapter.

little judicial or legislative attention has been paid to the problem of who is authorized to give consent for the incapable patient and less surprisingly, the practice varies considerably from state to state.⁴

Indiana's new Health Care Consent Act,⁵ effective April 24, 1987, provides statutory authority by which capable individuals may delegate to others the power to make health care decisions on their behalf in the event of their incapacity. In addition to this "proxy consent" provision, the Act codifies two other forms of consent to health care, "substituted consent," and "delegated consent by relatives."⁶ The Act also codifies the common law doctrine of when consent to one's own health care is valid consent.⁷ The Act, patterned after the Uniform Law Commissioner's Model Health Care Consent Act,⁸ takes an important step in furthering the individual's right to self-determination and autonomy through constitutional safeguards that are procedural in nature and which are not intended to affect the substantive areas of consent law. The Act purportedly is not designed to provide answers for the extraordinary cases, such as treatment of terminal illness, organ donation, or the treatment of mental illness; however, such situations as withdrawal of or withholding life-supportive measures may fall within the Act's coverage. Rather, it is written to provide guidance and assistance in the consent cases that occur daily and routinely in medical practice. In that sense, the Indiana Act provides welcome guidance in an area of health law that can be both confusing and inconsistent in its interpretation.

The purpose of this Article is to examine the provisions of the new Health Care Consent Act and explore some of the many issues that are inherent in legislation of such magnitude and import. This Article will review the various provisions of the new consent law and provide practical guidance to the health care provider in the application of those provisions. The interaction of Indiana's Living Wills and Life-Prolonging Procedures Act⁹ with the new law also will be analyzed.

II. CONSENT TO ONE'S OWN HEALTH CARE

It has long been recognized that a competent adult has the right to accept or refuse medical treatment.¹⁰ This right is founded in the common

⁴Meisel & Kabnick, *Informed Consent to Medical Treatment: An Analysis of Recent Legislation*, 41 U. PITT. L. REV. 407, 461-66 (1980).

⁵IND. CODE §§ 16-8-12-1 to -12 (Supp. 1987).

⁶*Id.* §§ 16-8-12-5 to -6.

⁷*Id.* § 16-8-11-1.

⁸MODEL HEALTH CARE CONSENT ACT (Uniform Law Commissioners) (1982).

⁹IND. CODE § 16-8-11-1 to -13 (Supp. 1987).

¹⁰*See Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986);

law of trespass and battery,¹¹ which serves to protect a person's interests in the integrity of his body and freedom from unauthorized physical contact. The right also finds support in the emerging common law doctrine recognizing an individual's right to self-determination. These common law doctrines have been reinforced by a series of cases holding that the constitutional right of privacy is broad enough to encompass choices regarding medical treatment.¹² The Health Care Consent Act recognizes that constitutional right in section 2 by prescribing who may consent to his own health care.

Section 2 of Indiana's Health Care Consent Act restates the common law doctrine that competent individuals have the right to consent to their own medical care.¹³ The section requires that adults be capable to give consent to their own health care for such consent to be valid.¹⁴ It also provides that certain minors may consent to their own health care if the minor is:

- (A) emancipated [as determined by the common law];
- (B) at least fourteen (14) years of age, is not dependent on a parent for support, is living apart from his parents and is managing his own affairs;
- (C) married or has been married;
- (D) in the military service of the United States; or
- (E) authorized to consent to the health care by any other statute.¹⁵

While the law has long recognized capable adults' rights to consent to their own health care, the capacity of minors to consent to health care has long troubled health care providers. At common law, minors were presumed incompetent and therefore not permitted to make health

Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 497 N.E.2d 626 (1986); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417, (1977); *In re* Quinlan, 70 N.J. 10, 40, 355 A.2d 647, 663 (1976) (constitutional right of privacy "broad enough to encompass a patient's decision to decline medical treatment under certain circumstances"), *cert. denied*, 429 U.S. 922 (1976); *In re* Yetter, 62 Pa. D. & C.2d 619, 623-24 (1973) (upholding the right of a state mental institution inmate to refuse surgery for breast cancer).

¹¹See *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 105 N.E. 92 (1914) (overruled on other grounds in *Bing v. Thunig*, 2 N.Y.2d 656, 163 N.Y.S.2d 3, 143 N.E.2d 3 (1957)) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.').

¹²*See* *Doe v. Bolton*, 410 U.S. 179, 213 (1973); *Roe v. Wade*, 410 U.S. 113, 153 (1973).

¹³IND. CODE § 16-8-12-2 (Supp. 1987).

¹⁴*Id.*

¹⁵*Id.* § 16-8-12-2(2)(A) to -(E).

care decisions.¹⁶ However, over the years both statutory and common law exceptions have evolved that render a minor capable of giving valid consent to certain forms of medical treatment, e.g., consent to drug/alcohol abuse treatment,¹⁷ blood donation,¹⁸ venereal disease treatment,¹⁹ and abortion.²⁰ These exceptions are based on public policy concerns about the spread of disease and the protection of a minor's confidentiality, as well as the policy of providing incentives for a minor to seek treatment. Further, the common law doctrine of emancipation has carved out exceptions to a minor's presumed incapacity to make health care decisions. These exceptions are based on the assumption that a minor who has made certain "adult-like" decisions or taken certain actions in his life has demonstrated capacity to make health care decisions.²¹ The emancipation exceptions are recognized in section 2(2)(A) & (B) of the Act.²²

Whereas section 2(2)(A) of the Act²³ embodies the traditional common law concept of emancipation, section 2(2)(B)²⁴ is an explicit emancipation provision based on objective criteria which will not require the provider to turn to common law or to a formal adjudication of emancipation before accepting consent. Accordingly, a health care provider should be protected if it accepts consent from minors who are at least fourteen, are not dependent on a parent, are living apart from parents, and are managing their own affairs. The age requirement of this section provides a statutory threshold above which a minor, if he meets the other criteria, may be presumed emancipated and may give valid consent to health care.²⁵ Otherwise, the adjudication of emancipation could be necessary if a minor is less than fourteen years of age and the health care provider

¹⁶42 C.J.S. INFANTS § 108 (1978).

¹⁷IND. CODE § 16-13-6.1-23 (1982).

¹⁸IND. CODE § 16-8-2-1 (Supp. 1987).

¹⁹*Id.* § 16-8-5-1.

²⁰IND. CODE § 35-1-58.5-2.5(b).

²¹See MODEL HEALTH-CARE CONSENT ACT (Uniform Law Commissioners) § 2 comment (1982).

²²IND. CODE § 16-8-12-2(2)(A), (B) (Supp. 1987).

²³*Id.* § 16-8-12-2(2)(A).

²⁴*Id.* § 16-8-12-2(2)(B).

²⁵IND. CODE § 16-8-3-1(b)(1982) (rewritten 1986, amended 1987). This section provided that consent could be given "if the patient is an emancipated minor, by the patient; provided further, that if such minor be married, then his or her spouse shall join in such consent." *Id.* The new consent law does not require the emancipated minor's spouse to join in the consent. The law also provides additional criteria to determine whether a minor is emancipated, e.g., at least fourteen years of age, is not dependent on a parent for support, is living apart from the minor's parents or from an individual *in loco parentis*, and is managing the minor's own affairs. IND. CODE § 16-8-12-2 (Supp. 1987).

is not assured that the minor meets the common law criteria of emancipation.

III. SUBSTITUTED CONSENT

Section 4 of the Act creates authority for certain persons to consent to health care on behalf of an incapable individual if no health care representative has otherwise been appointed under the Act.²⁶ In so providing, the legislature has now generally recognized the legal doctrine of "substituted consent." Substituted consent or substituted judgment is essentially a process whereby either the court or a surrogate act as the decision-maker for one who lacks such capacity.²⁷ Traditionally, the accepted practice among health care providers has been to obtain consent from the patient's spouse or next-of-kin, even though technically valid consent to medical treatment for an incompetent adult in Indiana could only be given by a court or the legal guardian of the patient after an adjudication of incompetency.²⁸ This has long been the law but seldom the practice. The Act now provides a priority list of those individuals, in addition to the courts and a legal guardian, who may exercise substituted consent on behalf of an incapable patient if no health care representative has otherwise been appointed under the Act.²⁹ This provision conforms with past practices of health care providers and as such provides a workable alternative to the judicial proceeding previously required under Indiana's consent law.³⁰ The persons who may give substituted consent for an incapable adult under the Act are:

- (1) a judicially appointed guardian of the person;³¹
- (2) a spouse, parent, adult child, *or* adult sibling; *or*³²
- (3) a religious superior.³³

²⁶IND. CODE § 16-8-12-4 (Supp. 1987).

²⁷See *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977).

²⁸See *supra* note 3.

²⁹IND. CODE § 16-8-12-4 (Supp. 1987).

³⁰IND. CODE § 16-8-3-1 (Supp. 1986) (current version at IND. CODE §§ 16-8-12-1 to -12 (Supp. 1987)).

³¹IND. CODE § 16-8-12-4(a)(1) (Supp. 1987).

³²*Id.* § 16-8-12-4(a)(2) (emphasis added). This provision does not purport to establish any priority between the individuals listed. Past practice of many health care providers when presented an incapable adult patient was to consult the spouse of the patient (if one existed) to obtain substituted consent. However, prior to the enactment of the Health Care Consent Act, only a legal guardian could make a binding consent decision on behalf of an incapacitated adult. IND. CODE § 16-8-3-1(c) (1982) (amended 1987). Thus, many procedures were performed every year without technically valid consent.

³³IND. CODE § 16-8-12-4(a)(3) (Supp. 1987).

The persons who may give substituted consent for a minor are:

- (1) a judicially appointed guardian of the person;
- (2) a parent or person *in loco parentis*; or
- (3) an adult sibling of the minor.³⁴

In their role as surrogate decision-maker, the court or the individual to whom consent authority was delegated under section 4 is expected to make medical choices on behalf of the incapable patient in good faith and in the patient's best interest.³⁵ Accordingly, the substituted consent-giver must answer the question: What would this particular patient do if he could make the decision for himself? By requiring the decision-maker to put himself in the patient's shoes, this legal standard directs him to act "as if" he were the patient's agent. The decision-maker should be guided by his knowledge of the patient's own feelings and desires. Even though the incapable patient is no longer able to make legally controlling choices, any present expressions and wishes should be respected as much as possible. In addition, the surrogate may ascertain the patient's wishes by either assessing sentiments expressed by the patient prior to incapacity, or by drawing reasonable inferences from an examination of the patient's prior conduct.³⁶

If it is impossible to ascertain the choice the patient would have made, then the surrogate decision-maker must do whatever is "in the patient's best interests." The "best interest" of the patient standard is generally thought to incorporate the concept of objective reasonableness—focusing on what would be wise, prudent or reasonable for the incapable patient to do, whereas a subjective substituted judgment standard will focus on the desires and preferences which the incapable person would have had except for his incapacity, given his present situation.³⁷

As the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research suggested:

In assessing whether a procedure or course of treatment would be in a patient's best interests, the surrogate must take into account such factors as the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of life sustained. An accurate assessment will encompass consideration of the satisfaction of present desires, the oppor-

³⁴*Id.* § 16-8-12-4(b)(1) to -(3).

³⁵*Id.* § 16-8-12-4(d).

³⁶AMERICAN HOSPITAL ASSOCIATION, OFFICE OF GENERAL COUNSEL, LEGAL MEMORANDUM NUMBER 9, DISCHARGING HOSPITAL PATIENTS: LEGAL IMPLICATIONS FOR INSTITUTIONAL PROVIDERS AND HEALTH CARE PROFESSIONALS, (June 1987) [hereinafter DISCHARGING HOSPITAL PATIENTS].

³⁷Fowler, *Appointing An Agent to Make Medical Treatment Choices*, 84 COLUM. L. REV. 985, 1003-4 (1984).

tunities for future satisfactions, and the possibility of developing or regaining the capacity for self-determination.³⁸

Ultimately, the standard against which the substituted decision-maker will be held will turn on the particular facts and circumstances of the individual case. In certain circumstances, health care providers may wish to seek legal counsel on whether a surrogate's action can withstand scrutiny under a "good faith" standard.

The priority list of consent-givers in section 4 raises another area of concern for health care providers—whether valid consent may be obtained when a disagreement exists between individuals in a particular category of consent-givers. For example, if the incapacitated patient's adult child exercises substituted consent to medical care under section 4(a)(2)³⁹ and the patient's spouse subsequently or concurrently disagrees with that consent, what are the options and obligations of the health care provider? The Act places no obligation upon the provider to obtain substituted consent from each individual in a particular category, nor are the individuals within the category listed in any order of preference. Accordingly, the health care provider obtains a valid consent if *any* individual within the category authorizes the treatment.⁴⁰ However, in the event of a dispute, the most conservative and safest course is to submit the issue to a court having probate jurisdiction for a decision based on the facts presented. At the very least, a health care provider should engage in further discussion among the parties to encourage a consensus opinion as to what treatment decision is in the best interest of the patient and document such decision and discussion in the patient's medical record. These judgment parameters should be embodied in institutional policy statements which delineate the appropriate circumstances leading to the acceptance of a surrogate decision-maker's substituted consent or to the initiation of a judicial proceeding. Until a legislative

³⁸PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, (1983).

³⁹IND. CODE § 16-8-12-4(a)(2) (Supp. 1987) provides that consent to health care of an incapable patient who has not otherwise appointed a health care representative may be given:

(2) by a spouse, parent, adult child, or adult sibling unless disqualified under section 8 of this chapter, if:

(A) there is no guardian or other representative described in subdivision (1);

(B) the guardian or other representative is not reasonably available or declines to act; or

(C) the existence of the guardian or other representative is unknown to the health care provider.

⁴⁰See *supra* note 26.

act determines a priority among those individuals authorized to exercise substituted consent, the health care provider must rely on the consistent application of sound judgment and clear policy should disagreements arise among authorized individuals.

A related issue concerns the duties and obligations of a hospital which arise when divorced parents disagree over the course of medical treatment that is appropriate for their minor child. Section 4(b)(2) of the Act clearly gives a parent the right to consent to health care for his or her minor child; however, it does not specify whether the parent must have physical or legal custody of the child to exercise such consent authority. Indiana Family law states:

Except as otherwise agreed by the parties in writing at the time of the custody order, the custodian may determine the child's upbringing, including his education, *health care*, and religious training, unless the court finds, after motion by a noncustodial parent, that in the absence of a specific limitation of the custodian's authority, the child's physical health would be endangered or his emotional development significantly impaired.⁴¹

Therefore, it is clear that when a custody order has been issued by the court, the custodial parent has the final say in the course of medical treatment to be delivered to his or her child and may legally exercise consent. However, health care providers may be faced with the situation where the court has awarded joint legal custody of a child pursuant to Indiana law⁴² and the parents disagree as to the appropriate course of medical treatment for the child. Although the Act is silent as to such a situation and "an award of joint legal custody does not require an equal division of physical custody of the child," as a practical matter, a health care provider is better advised to follow the wishes of the parent who has physical custody of the child at the time the health care decision is to be made than to seek consent from the parent not having present custody. Again, the hospital must be assured that the parent is acting in good faith and in the best interests of the child before obtaining such consent.

⁴¹IND. CODE § 31-1-11.5-21(b) (Supp. 1986) (emphasis added).

⁴²*Id.* § 31-1-11.5-21(f). This section provides:

The court may award legal custody of a child jointly if the court finds that an award of joint legal custody would be in the best interest of the child. As used in this section, "joint legal custody" means that the persons awarded joint custody will share authority and responsibility for the major decisions concerning the child's upbringing, including the child's education, *health care*, and religious training. An award of joint legal custody does not require an equal division of physical custody of the child.

Id. (emphasis added).

Another interesting provision of section 4 is the consent authority it grants to one who stands *in loco parentis* to a minor.⁴³ Who is *in loco parentis*? Blacks Law Dictionary defines *in loco parentis* as "In the place of a parent; instead of a parent; charged, factitiously, with a parent's rights duties, and responsibilities."⁴⁴

Indiana courts have addressed the issue of whether an individual stands *in loco parentis* to a minor in several cases.⁴⁵ Each judicial determination of whether an individual was *in loco parentis* turned on the factual circumstances of the case, with no clear guidelines emerging as to the determination of such a status.⁴⁶ Instead, the courts weighed the nature of the decision to be made by the individual alleged to be *in loco parentis* against the minor's constitutional protections and the public interest in such decisions being made by one other than the minor's parents.⁴⁷ The courts' decisions have ranged from finding that a teacher stands *in loco parentis* to students,⁴⁸ to finding that, absent strong indicia of a parental relationship, the *loco parentis* status will not be upheld.⁴⁹

The Health Care Consent Act gives no definition of *in loco parentis* and as such, leaves the determination of the status to the health care provider. Although the Act provides no specific rule, the guidance that can be gleaned from the Act in making this determination is found in the many constitutional protections of an individual's right to self-determination and autonomy that permeate the other sections of the Act. Given these many statutory safeguards, it would follow that the status of *in loco parentis* should be construed narrowly. A finding of *in loco parentis* should be determined by the existence or nonexistence of an individual: "[w]ho has put himself in the situation of a lawful parent by assuming the obligations incident to the parental relation without going through the formalities necessary to legal adoption. It [the term *in loco parentis*] embodies the two ideas of assuming the

⁴³IND. CODE § 16-8-12-4(b)(2) (Supp. 1987).

⁴⁴BLACK'S LAW DICTIONARY 896 (5th ed. 1979).

⁴⁵See *Swanson v. Wabash College*, 504 N.E.2d 327 (Ind. 1987); *Sturup v. Mahan*, 261 Ind. 373, 305 N.E.2d 877 (1970); *Indiana State Personnel Bd. v. Jackson*, 244 Ind. 321, 192 N.E.2d 740 (1965); *Browder v. Harmeyer*, 453 N.E.2d 301 (Ind. Ct. App. 1983); *R.D.S. v. S.L.S.*, 402 N.E.2d 30 (Ind. Ct. App. 1980); *Stout v. Tippecanoe County Dep't of Pub. Welfare*, 182 Ind. App. 404, 395 N.E.2d 444 (1979); *Bristow v. Konopka*, 166 Ind. App. 357, 336 N.E.2d 397 (1975); *Watson v. Department of Pub. Welfare*, 130 Ind. App. 659, 165 N.E.2d 770 (1960); *Kunkel v. Arnold*, 131 Ind. App. 219, 158 N.E.2d 660 (1959).

⁴⁶See cases cited *supra* note 45.

⁴⁷See cases cited *supra* note 45.

⁴⁸*Indiana State Personnel Bd. v. Jackson*, 244 Ind. 321, 192 N.E.2d 740 (1965).

⁴⁹*Sturup v. Mahan*, 261 Ind. 373, 305 N.E.2d 877 (1970).

parental status and discharging the parental duties."⁵⁰ It follows that a narrow construction of section 4 of the Act would prohibit a babysitter, teacher, camp counselor or similarly situated person from standing *in loco parentis* to a minor needing health care. Thus, the issue of whether a baby sitter, teacher, camp counselor or other similarly situated person stands *in loco parentis* to a minor needing health care would most likely be answered in the negative, given a narrow construction of the legal concept established under section 4 of the Act.

IV. PROXY CONSENT

Section 6 of the Act again extends the individual's right to self-determination and autonomy by permitting the appointment of another capable adult as a representative to make health care decisions on the appointor's behalf in the event of the appointor's incapacity.⁵¹ The appointment must be in writing,⁵² signed by the appointor or designee in the appointor's presence,⁵³ and witnessed by an adult.⁵⁴ The appointment becomes effective upon the appointor's incapacity⁵⁵ and is revocable by oral or written notification to the health care provider.⁵⁶ Furthermore, such a health care representative has priority to act over all others in matters affecting the appointor's health care.⁵⁷ This authority is governed by the express terms and conditions of the appointment and can thereby be limited at the direction of the appointor.⁵⁸

The appointment of a health care representative places the authority to make decisions on behalf of the appointor in the hands of an individual whom the appointor himself has chosen. Traditionally, the authority to make health care decisions for an incompetent or incapable individual has been placed in the hands of a judicially appointed guardian or the courts.⁵⁹ The prior appointment of a representative by an individual to speak on the individual's behalf when he is no longer able to speak for himself significantly enhances the individual's control over his own medical care. At the same time, the appointment of a medical agent affords the treating physician the certainty of obtaining legally binding consent from a sole decision-maker without resorting to the courts. Proxy de-

⁵⁰R.D.S. v. S.L.S., 402 N.E.2d 30 (Ind. Ct. App. 1980).

⁵¹IND. CODE § 16-8-12-6 (Supp. 1987).

⁵²*Id.* § 16-8-12-6(c)(1).

⁵³*Id.* § 16-8-12-6(c)(2).

⁵⁴*Id.* § 16-8-12-6(c)(3).

⁵⁵*Id.* § 16-8-12-6(f).

⁵⁶*Id.* § 16-8-12-6(j)(1).

⁵⁷*Id.* § 16-8-12-6(g).

⁵⁸*Id.* § 16-8-12-6(e).

⁵⁹*See supra* note 3.

cision-making by an appointed representative is also more consistent with the tradition of informed consent in that the representative can help assure that an incapable patient receives treatment in accord with his own wishes. The recognition of proxy consent by the legislature now gives the health care provider firm ground on which to stand when seeking consent to treat a patient who lacks decision-making capacity. Equally important, patients may now choose which individuals will exercise consent on their behalf in the event of their incapacity.

The authority of a duly appointed health care representative under the Act is governed by the expressed terms of the appointment itself⁶⁰ and may only be further delegated by the representative if so specified in the written appointment.⁶¹ Presumably, the representative possesses the same power and authority with respect to making health care decisions for the appointor as the appointor himself, except for the appointor's incapacity. However, the authority of the representative may be limited by the terms of the appointment. Furthermore, the representative must act "(1) in the best interest of the appointor consistent with the purpose expressed in the appointment; and (2) in good faith."⁶² This standard is no different than the standard imposed on an individual authorized to exercise substituted consent under section 4 of the Act; therefore, it may be reviewed on either a subjective or objective basis as discussed previously.⁶³

The "best interest" standard serves as a check and balance to the authority granted the health care representative. Most likely, any challenge to the health care representative's authority, absent acts contrary to the expressed terms of the appointment, will be made on the basis that the proxy consent decision is not in the best interest of the patient. This type of challenge can be handled the same way courts currently review the decision of a minor's parent or legal guardian to determine whether the patient's best interests are being served. The state, pursuant to its *parens patriae* authority, retains the power to intervene if a representative proposes to take steps plainly inconsistent with the welfare of the patient.⁶⁴ Accordingly, the health care provider is placed in a position of determining whether the surrogate decision-maker is acting in the patient's best interest. If it believes the surrogate is not acting consistent with the wishes and desires of the patient, then it has a duty to submit the

⁶⁰IND. CODE § 16-8-12-6(e) (Supp. 1987).

⁶¹*Id.* § 16-8-12-6(d).

⁶²*Id.* § 16-8-12-6(h)(1) -(2).

⁶³See *supra* notes 36-37 and accompanying text.

⁶⁴See generally *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied*, 429 U.S. 922 (1976); *In re Boyd*, 403 A.2d 744 (D.C. 1979) (the state must show a compelling state interest to override an adult patient's decision).

issue to the court. Again, this determination must be made based on the health care provider's good faith assessment of the patient's interests and the surrounding circumstances. The Act is not designed to keep all health care consent issues out of court, but instead, it is written to allow a patient to appoint a representative to act consistent with the patient's wishes and desires and in his best interest. Otherwise, the question may still require a judicial proceeding.

The "best interest" standard also raises issues with respect to the validity of a proxy decision-maker's consent to the withdrawal or withholding of life sustaining procedures. These issues will be discussed in section VII of this Article.

A. *Incapacity and Procedural Safeguards under the Act*

Pursuant to section 3 of the Act, the attending physician has the responsibility to determine whether a patient is capable of giving consent.⁶⁵ The appointment is executory in nature and therefore not effective until the appointor's attending physician has determined, in good faith, that the appointor is incapable of making a decision regarding the proposed health care.⁶⁶ It is important to note that the statute turns on the incapability or incapacity and not on the incompetence of a patient since a person may be *de jure* competent when in fact he is incapable of making a decision regarding his own health care. Additionally, the determination of incompetency usually involves a judicial proceeding. In contrast, section 3 of the Health Care Consent Act leaves the incapacity determination to the patient's attending physician's good faith opinion.

Health care professionals frequently disagree about how to evaluate a person who may be incompetent or incapable of making health care decisions on his own behalf. The fundamental principle that guides this inquiry is that "competence" relates to a patient's decision-making capacity rather than to his cognitive abilities. The question of competence or capacity should be approached from a "functional" standpoint which recognizes that regardless of the decision the patient ultimately makes or the clinical label attached to the patient, the key element is whether the patient is able to engage in rational decision-making.⁶⁷ The legislature has chosen "capacity" rather than "competence" to reflect its desire that the Act be a practical and workable guide, and that the decision

⁶⁵IND. CODE § 16-8-12-3(a) (Supp. 1987). "An individual otherwise authorized under this chapter may consent to health care unless, in the good faith opinion of the attending physician, the individual is incapable of making a decision regarding the proposed health care." *Id.*

⁶⁶*Id.*

⁶⁷See DISCHARGING HOSPITAL PATIENTS, *supra* note 36, at 8.

should be left to the attending physician, rather than the courts, absent contrary facts.⁶⁸

It seems likely that the physician will be in the best position to determine the patient's capacity to make medical decisions on the patient's own behalf. Nevertheless, some critics fear the physician now has an incentive to judge the patient incapable quickly in order to obtain consent from a health care representative or other substitute consent-giver, although in truth, the patient may not meet a judicial definition of incompetence or incapacity. However, section 3(b) evidences the legislature's concern for personal autonomy and the protection of individual rights and serves as a safeguard against hasty determinations of incapacity. It states:

A consent to health care under Section 4, 5, or 6 of this chapter [those authorized to give substituted consent] is not valid if the health care provider has knowledge that the individual has indicated contrary instructions in regard to the proposed health care, even if the individual is believed to be incapable of making a decision regarding the proposed health care at the time the individual indicates contrary instructions.⁶⁹

In so providing, section 3(b) would allow an individual to express contrary instructions to those of the health care representative or substitute consent-giver even if the individual is of questionable capacity. The health care provider, who knows of such contrary instructions, must abide by those instructions and cannot accept consent from the surrogate. This section further recognizes the personal nature of health care decision-making and seeks to protect the individual's right to control his own medical treatment until it is clear, in the good faith opinion of the attending physician, that he is no longer capable of such decision-making. Any health care professional whose ethical or moral value system prevents him from carrying out the wishes of a patient should encourage and facilitate the patient's transfer to a health care professional who will respect and honor the patient's decision.

Section 8 of the Act is yet another procedural safeguard which allows a capable individual to specifically disqualify others from consenting to health care for the individual.⁷⁰ The disqualification may be made in the same instrument used to appoint a health care representative or it may be made in a separate document. The disqualification must be in

⁶⁸See MODEL HEALTH-CARE CONSENT ACT (Uniform Law Commissioners) § 3 comment (1982).

⁶⁹IND. CODE § 16-8-12-3(b) (Supp. 1987).

⁷⁰*Id.* § 16-8-12-8.

writing, signed by the individual, and specifically identify those who are disqualified from exercising consent.⁷¹ A health care provider who knows of a written disqualification may not accept consent to health care from a disqualified individual.⁷² This section again shows the legislative intent to fully protect an individual's autonomy and constitutional right to privacy with respect to health care decisions.

Further safeguards for the individual are evidenced in section 6 which provides for easy revocation of an appointment of a health care representative.⁷³ The appointment is revocable by the appointor, when capable, by either oral or written notice to the representative or to the health care provider.⁷⁴ The health care representative may also resign or refuse to comply with the written appointment. In the latter event, the health care representative has a duty to inform the appointor,⁷⁵ the appointor's legal representative,⁷⁶ and the health care provider.⁷⁷ The representative may subsequently exercise no further power under the appointment.⁷⁸

B. Health Care Decisions and the Durable Power of Attorney

The Health Care Consent Act provides authority specific to the delegation of health care decision-making power.⁷⁹ Even so, the health care provider may continue to face the question of the validity of a power of attorney to make the same type of treatment decisions. Several states have enacted legislation which explicitly or impliedly authorizes an individual to appoint an attorney-in-fact to make medical decisions in the event the principal subsequently becomes incapable.⁸⁰ In other states, as in Indiana, it has been argued that the Durable Power of Attorney statutes, which allow the authority of an agent to continue even where the principal becomes incapable, can be construed to authorize the agent to make health care decisions on behalf of the principal. Proponents point to the lack of language in the Durable Power of

⁷¹*Id.* § 16-8-12-8(b).

⁷²*Id.* § 16-8-12-8(c).

⁷³*Id.* § 16-8-12-6(j).

⁷⁴*Id.* § 16-8-12-6(j)(1) to -(2).

⁷⁵*Id.* § 16-8-12-6(i)(1).

⁷⁶*Id.* § 16-8-12-6(i)(2).

⁷⁷*Id.* § 16-8-12-6(i)(3).

⁷⁸*Id.* § 16-8-12-6(i).

⁷⁹*Id.* §§ 16-8-12-5 to -6.

⁸⁰*See, e.g.,* DEL. CODE ANN. tit. 16, § 2502(b) (1983); CAL. CIVIL CODE § 2431(a) (West Supp. 1987); VA. CODE ANN. § 54-325.8:1 (Supp. 1987); FLA. STAT. ANN. § 765.07(b) (West 1986); IOWA CODE ANN. § 144 A.7 (West Supp. 1987-88); TEX. HEALTH & SAFETY CODE ANN. § 4590 h.3(e) (Vernon Supp. 1987).

Attorney statute prohibiting such a use as evidence that such use is possible, while opponents point to the lack of authorizing language as an indication that such use is invalid. Indiana courts have yet to consider the question.

Indiana's Durable Power of Attorney statute⁸¹ does not enlarge the powers that may be given under a valid power of attorney. Indiana follows the general rule that a power of attorney may only grant the power to dispose of or deal with real or personal property.⁸² As such, it does not explicitly or impliedly authorize the delegation of health care decision-making. Particularly, the Durable Power of Attorney statute does not contain the procedural and substantive safeguards that are present in the Health Care Consent Act. It would be unwise for an individual to use the Durable Power of Attorney vehicle to appoint an attorney-in-fact to make health care decisions on the individual's behalf, when section 6 of the Health Care Consent Act was enacted specifically for such a purpose. Attorneys and health care providers are well advised to rely on the specific authority granted by the Health Care Consent Act instead of risking the invalidity of a Durable Power of Attorney to delegate the principal's health care decision-making power to another individual in the event of the principal's incapacity.

V. DELEGATED CONSENT BY RELATIVES

Section 5 of the Health Care Consent Act provides that a spouse, parent, adult child or adult sibling may delegate their substituted consent authority to another individual if, for a period of time, the person will not be reasonably available to exercise such authority.⁸³ Such a delegation must be in writing, signed and witnessed by an adult.⁸⁴ The designee cannot further delegate this authority unless specifically authorized in the instrument.⁸⁵ The designee has the same authority and responsibility as the delegant unless specifically limited in the written delegation.⁸⁶

This provision could have utility in situations where parents want to delegate their health care decision-making power for their minor children to a temporary custodian of their children, for instance when parents plan to be unavailable or when a child is living at camp. The delegation of authority is broader in some aspects than that currently

⁸¹IND. CODE § 30-2-11-1 to -7 (Supp. 1987).

⁸²Hadley v. Hadley, 147 Ind. 423, 46 N.E. 823 (1897); *See generally* 23 I.L.E. Powers § 1 (1970).

⁸³IND. CODE § 16-8-12-5(a) (Supp. 1987).

⁸⁴*Id.*

⁸⁵*Id.*

⁸⁶*Id.*

allowed under Indiana Code section titled, "Parents or Guardians; Delegation of Powers."⁸⁷ This section of the Indiana Code allows a parent to make a similar delegation through a properly executed Durable Power of Attorney.⁸⁸ However, the delegation is limited to sixty (60) days and to those situations where the parent is to be outside of the state or physically incapacitated.⁸⁹ Section 5 of the new Act allows the delegation to be operative for a reasonable period of time during which the parents are not otherwise available, and is not limited to those instances where the parent is out of the state.⁹⁰ For these reasons, the delegation of a parent's health care decision-making authority for their minor child is better effected through section 5 of the Health Care Consent Act which was enacted specifically for such a delegation.

VI. OTHER PROVISIONS OF THE ACT

Section 1 defines the various terms used in the new Act.⁹¹ It states the Act applies to health care providers as defined in Indiana's Medical Malpractice Statute⁹² (which now includes nursing homes, and certain corporations and partnerships).⁹³ The section also limits the consent authority of an authorized individual to "health care" decisions, which by definition includes consent to admission to a health care facility, but does not include a mental health facility.⁹⁴

Section 7 of the Act gives specific authority for a health care provider or any interested party to petition the probate court to: (1) make a health care decision or order health care for an individual incapable of consenting; or (2) appoint a representative to act for that individual.⁹⁵ This section may provide an alternative to the appointment of a guardian to make health care decisions for a ward under Indiana's Temporary Guardian Statute.⁹⁶ Normally, when an Indiana health care provider is presented with an incompetent patient to whom it wishes to render medical treatment and no individual is present who possesses valid consent

⁸⁷*Id.* § 29-1-18-28.5.

⁸⁸*Id.*

⁸⁹*Id.*

⁹⁰*Id.* § 16-8-12-5.

⁹¹*Id.* § 16-8-12-1.

⁹²*Id.* § 16-8-12-1(3). This section provides: "'Health care provider' has the meaning set forth in I.C. 16-9.5-1-1. The term also includes a health facility as defined in I.C. 16-10-4-2.'" *Id.*

⁹³Pursuant to House Enrolled Act No. 1210, codified at IND. CODE § 16-9.5-1-1(a) (effective September 1, 1987).

⁹⁴IND. CODE § 16-8-12-1(2) (Supp. 1987).

⁹⁵*Id.* § 16-8-12-7(a)(2).

⁹⁶IND. CODE § 29-1-18-24 (1982).

power (or such individual is present but refuses to exercise that power—such as the case where a Jehovah's Witness parent refuses to consent to a blood transfusion for his minor child), the health care provider petitions the probate court to appoint a temporary guardian to consent to the medical treatment on behalf of the incompetent.⁹⁷ Seemingly, section 7 is tailored to this type of decision and may provide for a better procedure by which the court may appoint a representative to make health care decisions on behalf of the incapable patient.

However, the health care provider seeking the appointment of a health care representative under section 7 is cautioned of two potential drawbacks. First, in a temporary guardianship proceeding, the court usually orders the guardian to consent to one isolated instance of treatment after which the temporary guardian has exhausted his powers and the guardianship terminates.⁹⁸ If a health care representative is appointed under the new Act he appears to have the ability to consent to any type of health care, including the consent to withhold treatment, which may be contrary to the purpose of the judicial proceeding in the first place.

Another potential drawback to the use of Section 7 for the appointment of a health care representative is that Section 7 grants the probate court jurisdiction but does not provide a place of preferred venue. Pursuant to House Enrolled Act Number 1404 which amended the Probate Code, effective September 1, 1987, preferred venue for the appointment of a temporary guardian may be in *either* the county where the health care facility offering the services is located or in the incompetent's county of residence.⁹⁹ The preferred venue question may be a very important issue because many cases present situations where the patient has been transferred from another county. Under the Health Care Consent Act, the probate court would be compelled to grant a motion for change of venue to the incompetent's county of residence if such a motion was made by opposing counsel.¹⁰⁰ The change of venue would undoubtedly consume valuable time in a situation that often may present life and death issues. Thus, section 7 could be limited to those cases where the patient's residence is in the county of the facility providing the health care services. Regardless, an appointment of a health care representative under section 7 can be limited to consent authority for a specific medical procedure and the petition should ask the court to order the representative to consent to the treatment if the testimony

⁹⁷*Id.*

⁹⁸IND. CODE § 29-1-18-24, 47(b)(4) (1982 & Supp. 1987).

⁹⁹*Id.* § 29-1-18-7(1).

¹⁰⁰IND. CODE § 16-8-12-7 (Supp. 1987).

indicates the treatment is medically necessary. Also, because the authority of a health care representative does not automatically terminate, as does the authority of a temporary guardian, the health care representative may be required to make periodic reports to the appointing court regarding the patient's status and the need for consent authority.

Section 9 grants immunity from criminal or civil liability and professional discipline if the health care provider follows the provisions of the Act in good faith.¹⁰¹ As such, the health care provider is permitted to rely on the consent of an individual whom he, in good faith, believes is authorized to consent to health care.¹⁰² The immunity provided in this section does not protect a substitute decision-maker from liability arising from negligence or other breach of duties, but only from liability for acting without authority if he in good faith believes that he is authorized to give consent.¹⁰³

Section 10 provides that persons authorized to give consent under the Act have the same right to receive relevant medical information and health records as the appointor, and may consent to the release of medical records by a health care provider.¹⁰⁴ This section guarantees the right to receive relevant information but makes no attempt to define the scope of disclosure required by the health care provider. Presumably, the representative has the same right to medical information as the patient.

Section 11 provides that Chapter twelve is not to affect Indiana law concerning the consent to withdraw or withhold medical care, nor is it meant to affect the requirements of any other law concerning consent to observation, diagnosis, treatment, or hospitalization for a mental illness.¹⁰⁵ Further, the Act is not to affect Indiana law concerning health care provided without consent in an emergency.¹⁰⁶ Section 11 notwithstanding, it is inevitable that the issue will arise as to whether a surrogate decision-maker may give valid consent to the withholding or withdrawal of medical treatment on behalf of the appointor.

VII. WITHHOLDING OR WITHDRAWING LIFE-SUPPORTING PROCEDURES UNDER THE HEALTH CARE CONSENT ACT

The medical and legal professions have long struggled with the issue of when withholding or withdrawing life-supporting measures from a

¹⁰¹*Id.* § 16-8-12-9(a).

¹⁰²*Id.* § 16-8-12-9(b).

¹⁰³MODEL HEALTH-CARE CONSENT ACT (Uniform Law Commissioners) § 9 comment (1982).

¹⁰⁴IND. CODE § 16-8-12-10 (Supp. 1987).

¹⁰⁵*Id.* § 16-8-12-11(a) -(b).

¹⁰⁶*Id.* § 16-8-12-11(e)(5).

terminally ill patient is medically indicated, legally sound and in the patient's best interests. As well, the state, through its role of *parens patriae*, has an interest in the life and death of its citizens and may prolong an individual's life, even against his expressed desires.¹⁰⁷ In reality, competent patients do not have an unqualified right to make health care decisions concerning their treatment when balanced against compelling state interests. However, the trend has been to give increasing weight to the individual's right to control his own medical treatment.¹⁰⁸ Indiana's Living Wills and Life-Prolonging Procedures Act,¹⁰⁹ and now the Health Care Consent Act,¹¹⁰ are manifestations of the increasingly strong affirmation that an individual should have substantial control over his medical care. The doctrine of informed consent is the foundation upon which this affirmation stands, and both of these Indiana statutes build upon that important concept.

Section 11(a) of the Health Care Consent Act states: "This chapter does not affect Indiana law concerning an individual's authorization to make a health care decision for the individual or another individual, or to provide, withdraw or withhold medical care necessary to prolong or sustain life."¹¹¹

As such, the Health Care Consent Act was not intended to affect Indiana's Living Wills and Life-Prolonging Procedures Act. However, when considering the two Acts separately, there is clear legislative pronouncement that, on the one hand, a competent adult diagnosed as having a terminal condition may give valid consent to the withdrawal or prolongation of life-supporting procedures through a declaration made prior to becoming incapacitated.¹¹² On the other hand, the same individual has the right to appoint another person to make health care decisions on his behalf in the event of his incapacity.¹¹³ Given the legislative intent of the two Acts, the question arises whether an individual authorized to exercise consent under the Health Care Consent Act may consent to

¹⁰⁷See *supra* note 64.

¹⁰⁸See, e.g., *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); *Bartling v. Superior Court*, 103 Cal. App. 2d 186, 209 Cal. Rptr. 220 (1984); *John F. Kennedy Memorial Hosp., Inc. v. Bludworth*, 452 So. 2d 921 (Fla. 1984); *In re Farrell*, 529 A.2d 404 (N.J. 1987); *Matter of Requena*, 213 N.J. Super. 475, 517 A.2d 886 (1986); *In re Conroy*, 188 N.J. Super. 523, 457 A.2d 1232 (1983), *rev'd*, 190 N.J. Super. 453, 464 A.2d 303 (1983), *rev'd*, 90 N.J. 321, 486 A.2d 1209 (1985); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied sub. nom. Garger v. New Jersey*, 429 U.S. 922 (1976).

¹⁰⁹IND. CODE §§ 16-8-11-1 to -22 (Supp. 1987).

¹¹⁰*Id.* §§ 16-8-12-1 to -12.

¹¹¹*Id.* § 16-8-12-11(a).

¹¹²*Id.* § 16-8-11-11.

¹¹³*Id.* § 16-8-12-6.

the withdrawal or withholding of life-supporting measures on behalf of the terminally ill patient.

A. Ascertaining the Intent of the Declarant in a Living Will

It is clear that a health care provider presented with an individual who has expressed his desires in a properly executed living will may withdraw or withhold life-supporting procedures with little risk of civil or criminal liability or professional discipline.¹¹⁴ However, under the Living Wills statute, the attending physician who questions the validity of a living will is to consult with *any* of the following individuals to ascertain the intent of the declarant:

- (1) The judicially appointed guardian of the person of the patient if one has been appointed. . . .
- (2) The person or persons designated by the patient in writing to make the treatment decision for the patient should the patient be diagnosed as suffering from a terminal condition.
- (3) The patient's spouse.
- (4) An adult child of the patient or, if the patient has more than one (1) adult child, by a majority of the children who are reasonably available for consultation.
- (5) The parents of the patient.
- (6) An adult sibling of the patient or, if the patient has more than one (1) adult sibling, by a majority of the siblings who are reasonably available for consultation.
- (7) The patient's clergy or others with first hand knowledge of the patient's intention.¹¹⁵

In the author's opinion the Health Care Consent Act provides clearer guidance for the provider by giving a priority list of who may be consulted to ascertain the declarant's intent before carrying out the terms of a questionable living will declaration.¹¹⁶ It would seem prudent that the attending physician turn to the priority list of those who may exercise substituted consent under the Health Care Consent Act, or to the health care representative if one has been appointed, to determine the intent of the patient in the event the physician questions the validity of the living will declaration. In other words, the attending physician may be advised to follow the priority list under the Health Care Consent Act rather than make an individual choice from among the seven categories of authorized individuals under the Living Wills and Life-Prolonging

¹¹⁴*Id.* § 16-8-11-10.

¹¹⁵*Id.* § 16-8-11-14(g)(1) -(7).

¹¹⁶*Id.* § 16-8-12-4.

Procedures Act to determine the intent of the patient with respect to a questionable living will. If the physician and the surrogate agree that the living will was validly executed and that it evidences the intent of the declarant, the attending physician may wish to obtain the consent of that surrogate before carrying out the terms of the living will. Even absent such consent, the physician has an obligation to carry out the terms of the living will once he is convinced of its validity, or to transfer the patient to a physician who will honor the declaration.¹¹⁷ In any event, the consent of the health care representative to the withholding or withdrawal of life-supporting treatment under the Living Wills statute provides one more important safeguard in a situation that is both medically and legally significant. Therefore, the presence of such surrogate consent in the patient's medical record is advised.

B. Consent to Withholding of Life-Supporting Measures

Absent a valid will and any expressed terms in a written delegation, the attending physician may turn to the Health Care Consent Act's definition of "health care" to determine the scope of decision-making authority possessed by the representative, and whether that scope encompasses consent to the withdrawal or withholding of life-supporting procedures.¹¹⁸ Under the Act, health care is defined as: "[a]ny care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition. The term includes admission to a health care facility."¹¹⁹ One interpretation of this definition is that in order for a proxy decision-maker to give legal consent to the withdrawal or withholding of life-supporting measures, the Act's definition of health care must be construed to include the withdrawal or withholding of medical care as "treatment."

The withholding of life-supporting procedures is most often pursuant to a physician's written order to "Do Not Resuscitate" (DNR). A "Do Not Resuscitate" order is a physician's order not to begin life-supporting measures or resuscitative measures in the expected event of cardiac and/or respiratory arrest. The Health Care Consent Act¹²⁰ and the Living Wills and Life Prolonging Procedures Act¹²¹ codify the common law principle that a competent patient may consent to, or refuse consent, to medical treatment even though a refusal to consent to treatment may result in the patient's death.¹²² Accordingly, a competent individual may

¹¹⁷*Id.* § 16-8-11-14(e).

¹¹⁸*Id.* § 16-8-12-1(2).

¹¹⁹*Id.* § 16-8-12-1(2).

¹²⁰*Id.* §§ 16-8-12-1 to -12.

¹²¹*Id.* §§ 16-8-11-1 to -22.

¹²²*Id.* §§ 16-8-11-10(a), 16-8-12-2(1).

instruct his physician not to institute life-supporting measures or resuscitative measures in the event of cardiac and/or respiratory arrest. This analysis supports the contention that the withholding of life-supporting measures is to be construed as a form of medical treatment to which a competent patient may or may not consent, and as such may fall within the Act's definition of health care.

There are no Indiana statutes or precedents addressing "Do Not Resuscitate" orders or other orders to withhold treatment in cases where incompetent or incapable patients have not executed a living will. However, courts in several other states have expressed their opinion that there is no necessity for physicians and family members to seek court guidance in making such health care decisions on behalf of the incompetent patient.¹²³ Given such rulings and the opinion of the author that the withholding of life-supporting measures constitutes medical treatment to which a competent patient may consent, and the intent of the legislature to preserve the patient's autonomy to make decisions concerning his own health care, it follows that, absent expressed terms to the contrary, an individual authorized under the Health Care Consent Act to consent to health care for an incapable patient, may give valid consent to a DNR order or other order to withhold life-supporting measures. The DNR order may thus be a form of health care contemplated by the Act to which substituted, proxy, or delegated consent may be given, section 11 notwithstanding.

C. *Consent to the Withdrawal of Life-Supporting Measures*

The issue of whether a proxy, substituted, or delegated consent-giver may consent to the *withdrawal* of life-supporting measures as medical treatment presents a similar legal analysis as the withholding of treatment. However, from an emotional and practical standpoint it may be more difficult to resolve. From some perspectives, the withdrawal of life supporting procedures may be more of an affirmative act to end one's life than the withholding of those procedures, and as such may be an even harder decision for the individual patient or his representative to make. However, the court decisions have uniformly held life-supporting measures may be terminated under exactly the same circumstances in which a decision not to institute them would be proper.¹²⁴ Arguably

¹²³See *supra* note 108. See also *In re Dinnerstein*, 6 Mass. App. Ct. 466, 475-6, 380 N.E.2d 134, 139 (1978) (declaring: "[T]hat on the findings made by the judge the law does not prohibit a course of medical treatment which excludes attempts at resuscitation in the event of cardiac or respiratory arrest and that the validity of an order to that effect does not depend on prior judicial approval.').

¹²⁴See cases cited *supra* notes 108.

then, the Health Care Consent Act would also give a health care representative or other individuals authorized under the Act the authority to consent to the withdrawal of life-supporting measures as a form of consent to "health care."

Conversely, the consent to the withdrawal of health care may not be contemplated by the Act in light of section 11, and may be an overly broad construction of the legislative intent of the Act. Accordingly, it is incumbent upon the health care provider and its legal counsel to determine what risks are presented in each case before accepting substituted or proxy consent to the withdrawal of life supporting measures under the new Act. The safest and most conservative course is always through a court of competent jurisdiction and may well be the best route pending further legislative or judicial clarification of the Act's application in life and death decisions.

VIII. CONCLUSION

Indiana's new Health Care Consent Act is a legislative measure to clarify some of the many issues that have existed in Indiana consent law. By recognizing the concepts of substituted consent, proxy consent, and delegated consent by relatives, the Act provides to the health care professional a much needed statutory guide. It also provides certain immunities to the health care provider who proceeds in good faith to obtain necessary consent to health care. Equally important, the Act provides procedural safeguards designed to protect an individual's rights to self-determination and privacy with respect to health care decisions.

Clearly the Act is not a panacea for each and every problem of informed consent faced by a health care provider, but it is a bright light in a traditionally dark corner of Indiana consent law. As such, it can make the path of the health care provider less treacherous.

