HISTORY AND JURISPRUDENCE OF THE PHYSICIAN-PATIENT RELATIONSHIP IN INDIANA

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INTRODUCTION

Common law principles have and continue to govern the physician-patient relationship, the foundation upon which health care delivery is based. A strong physician-patient relationship is essential to successful medical treatment, and sound legal rules delineating the contours of that relationship are necessary to support the development of strong physician-patient relationships.

Indiana courts have made a significant contribution in this area. In so doing, Indiana courts have well served both the patients and physicians of Indiana. In addition, Indiana court decisions have been models for the courts of other states as they address the fundamental legal issues regarding the physician-patient relationship.

This Article first reviews some important history about the health care system in Indiana. It then examines how Indiana jurisprudence regarding the physician-patient relationship has evolved since the state's early years. Finally, the Article addresses future challenges that Indiana law faces with respect to the delineation of the physician-patient relationship.

I. HISTORY

The historical context in which Indiana's jurisprudence on the physician-patient relationship evolved is instructive. It explains, in part, why the Indiana judiciary has had the opportunity to provide innovative legal analysis and guidance on the physician-patient relationship and, in particular, the problems that arise in this relationship.

Indiana has many significant accomplishments in the health care field. Specifically, the first medical society in the Northwest Territory was established in Vincennes, Indiana, prior to 1818. An early commentator noted this event:

> The first medical society organized in the Northwestern Territory. . . occurred in Vincennes, Ind[iana]. The exact date is not positively known, but I know for a fact that its origin was prior to the year 1818. . . . I have evidence, obtained from a newspaper published in this town. . . . No known records of this society exist.[1]

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1. G.W.H. KEMPER, A MEDICAL HISTORY OF THE STATE OF INDIANA 18-19 (1911) (internal quotations omitted).

The Sanitary Revolution and the discovery of the bacterial origin of infectious disease in the latter part of the nineteenth century[2] brought governmental efforts to improve public health.[3] In 1881, Indiana was one of the first states to enact public health legislation and establish a state health department.[4] It was not smooth sailing for a state agency devoted to public health in those early years. Dr. Hurty, one of the first state health officers, reported his exchange over some public health measures with a recalcitrant state legislator who closed the conversation with this remark: "I will tell you what can be done. We will get a resolution through [the legislature] to abolish the whole health business."[5] Obviously, this prescient legislator did not foresee the future development of the health care system nor the extensive involvement of both the legislature and judiciary in the law of the "health business."

Attempts were made to establish a medical school in Indiana as early as 1839; however, they were ultimately unsuccessful.[6] Indiana University established its school of medicine in 1903. Today, the School of Medicine, located in Indianapolis, is one of the largest in the United States and trains most of Indiana's physicians.[7]

Over the years, Indiana has also developed several leading hospitals. Wishard Memorial Hospital, Indianapolis's oldest hospital, is one of the nation's largest providers of health care services to the indigent.[8] Other leading hospitals with national reputations abound throughout the state and have a distinguished history.[9]

Through the years, Indiana has continued its leadership in the health care sector. Even in the later development of the law governing third party payment, Indiana and its lawyers played a pivotal role. In the years after the inauguration of the Medicare[10] program in 1965, Indiana hospital lawyers were leaders in challenging the Medicare cost reimbursement rules perceived to be unfair. For example, in 1979, the Indiana Hospital Association argued successfully before the Provider Reimbursement Review Board, the administrative tribunal which adjudicates Medicare payment disputes with hospitals,[11] that nonprofit hospitals

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2. 25 ENCYCLOPAEDIA BRITANNICA 454-56 (15th ed. 1986).

3. GEORGE ROSEN, A HISTORY OF PUBLIC HEALTH 192-93 (1958).

4. Act of Mar. 7, 1881, ch. 19, 1881 Ind. Acts 37 (repealed 1949). *See* IND. CODE §§ 16-19-1-1 to -3 (1993) (establishing the state department of health); *id.* §§ 16-19-3-1 to -25 (1993 & Supp. 1996) (duties of state department of health).

5. Indiana State Department of Health, Changes in Health Care Policy 5 (1995) (unpublished paper on file with the *Indiana Law Review*). We are indebted to our colleagues at the Indiana State Department of Health for bringing this legislator's futuristic vision to our attention.

6. KEMPER, *supra* note 1, at 20-21.

7. ENCYCLOPEDIA OF INDIANAPOLIS 760 (David J. Bodenhamer et al. eds., 1994).

8. *Id.* at 1432.

9. *Id.* at 711-14, 1104, 1196, 1214-15.

10. Health Insurance for the Aged (Medicare) Act, Pub. L. No. 89-97, 79 Stat. 290 (1965) (codified as amended in scattered sections of 26 U.S.C., 42 U.S.C., and 45 U.S.C.).

11. 42 U.S.C. § 1395oo (1994).

were entitled to a return on equity capital under the old Medicare cost reimbursement rules for hospitals.[12] Eventually, the federal courts upheld the Secretary of Health and Human Services' reversal of this decision.[13]

Indiana has also provided the nation with leadership regarding reforms in the procedures for adjudicating medical malpractice cases. In 1975, under the guidance of its physician-governor, Otis R. Bowen, Indiana enacted an innovative medical malpractice statute that imposed a cap on recoverable damages and other reforms.[14] Indiana's comprehensive reforms were among the first in the country to be implemented in response to increased medical malpractice claims and the escalating cost of malpractice premiums for health care providers.[15] The act and its various reforms have been adopted by other states and have also been included in bills for malpractice reform at the federal level.[16] Further, empirical research demonstrated that Indiana's reformed system actually provided claimants having large claims with more compensation than neighboring states which had not adopted those reforms.[17]

In 1980, the Indiana Supreme Court in *Johnson v. St. Vincent Hospital, Inc.*[18] upheld the constitutionality of Indiana's act. This decision has been recognized by at least one prominent scholar as the appropriate analysis of the constitutionality of damage caps, screening panels, and other reforms.[19] Further, after several earlier state court decisions invalidated comparable malpractice reforms, the trend among state courts has been to uphold malpractice reform statutes with damage caps and screening panels on the same grounds as the

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12. PRRB Dec. No. 79-D95, Dec. 17, 1979 [1979-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 30,163, *aff'd in part and rev'd in part,* HCFA Admr. Dec., Feb. 15, 1980 [1980 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 30,333.

13. Indiana Hosp. Ass'n v. Schweiker, 544 F. Supp. 1167 (S.D. Ind. 1982), *aff'd sub nom.* St. Francis Hosp. Ctr. v. Heckler, 714 F.2d 872 (7th Cir. 1983). *See generally* Eleanor D. Kinney, *Medicare Payment to Hospitals for A Return on Equity Capital: The Influence of Federal Budget Policy on Judicial Decision-Making*, 11 J. CONTEMP. L. 453 (1985).

14. Act of Apr. 17, 1975, No. 146, 1975 Ind. Acts 854 (repealed 1993) (current version at IND. CODE §§ 27-12-14-1 to -5 (1993)).

15. Eleanor D. Kinney & William P. Gronfein, *Indiana's Malpractice System: No-Fault By Accident?*, 54 LAW & CONTEMP. PROBS. 169, 171 (1991).

16. *See* Randall R. Bovbjerg, *Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card,* 22 U.C. DAVIS L. REV. 499, 521-31 (1989). *See also* Eleanor D. Kinney, *Malpractice Reform in the 1990s: Past Disappointments, Future Success?*, 20 J. HEALTH POL., POL'Y & L. 99, 110-19, 112-13, tbls. 1-2, app. A (1995).

17. William P. Gronfein & Eleanor D. Kinney, *Controlling Large Malpractice Claims: The Unexpected Impact of Damage Caps*, 16 J. HEALTH POL., POL'Y & L. 441, 441 (1991).

18. 404 N.E.2d 585 (1980). In *Johnson*, the court upheld the act against the challenge that the act violated article I, section 23 of the Indiana Constitution. *Id.* at 597. Since the decision in that case, the Indiana Supreme Court has changed its interpretation of that constitutional provision. Collins v. Day, 644 N.E.2d 72 (Ind. 1994).

19. PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL 41 (1991).

Indiana Supreme Court in *St. Vincent.*[20]

More recently, Indiana demonstrated significant leadership in its public response to the AIDS epidemic. In the early 1980s, the public school authorities in Kokomo, Indiana sought to prevent young Ryan White, who had contracted AIDS from a blood transfusion for hemophilia, from attending public school.[21] Ryan White challenged the decision of the school authorities.[22] The Clinton Circuit Court eventually upheld Ryan's right to attend public school.[23] Responding to the Ryan White controversy, the Indiana State Commissioner of Health publicly and emphatically supported Ryan White's right to attend school in light of the non-contagious nature of the AIDS (HIV) virus in a school setting.[24] This enlightened attitude has been demonstrated in other areas. Commentators have put Indiana ahead "of other states with its statewide services plan and network of community action groups" regarding its treatment of the AIDS epidemic.[25] Ultimately, Ryan White became a symbol of the AIDS tragedy in the United States. The federal legislation supporting various AIDS-related programs bears Ryan's name—the Ryan White Comprehensive AIDS Resources Emergency Act.[26]

Indiana has also demonstrated leadership in legislation addressing complex end-of-life decisions and planning. Specifically, in 1985, Indiana enacted the Living Wills and Life-Prolonging Procedures Act.[27] This act permits a competent person to provide binding direction on whether to withhold life-prolonging medical procedures.[28] In addition, the Indiana legislature has enacted the Health Care Consent Act (HCCA),[29] a durable power of attorney statute that permits the appointment of health care representatives to make decisions in the event of incompetence. In so doing, Indiana was the first state to adopt the Model Health-Care Consent Act.[30]

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20. *Id.* at 42-43.

21. *See* Lawrence Kilman, *Nation's School Officials Seek Guidelines for Dealing with AIDS in the Classroom*, INDIANAPOLIS STAR, Aug. 4, 1985, at 22; *AIDS Ruling Defied*, CHI. TRIB., Dec. 19, 1985, at 3; *Court Rulings in Other AIDS Cases*, L.A. TIMES, Sept. 9, 1987, at 6.

22. Kilman, *supra* note 21, at 22.

23. *Teenage AIDS Victim Back in Class After Indiana Judge Lifts Injunction*, ATLANTA J. & CONST., Apr. 10, 1986, at A02.

24. *See* Kilman, *supra* note 21, at 22.

25. *Glare of Media Dogs 14-Year-Old AIDS Victim*, THE OTTAWA CITIZEN, Sept. 2, 1986, at B16.

26. Pub. L. No. 101-381, 104 Stat. 576 (1990) (codified in scattered sections of 42 U.S.C.).

27. IND. CODE §§ 16-36-4-1 to -13 (1993 & Supp. 1996). *See* Carol A. Mooney, *Indiana's Living Wills and Life-Prolonging Procedures Act: A Reform Proposal*, 20 IND. L. REV. 539 (1987).

28. IND. CODE § 16-36-4-8 (1993).

29. IND. CODE §§ 16-36-1-1 to -14 (1993). *See generally* William H. Thompson, *Indiana's New Health Care Consent Act: A Guiding Light for the Health Care Provider*, 21 IND. L. REV. 181 (1988); Linda S. Whitton, *Health Care Advance Directives: The Next Generation*, RES GESTAE, June 1995, at 18.

30. MODEL HEALTH-CARE CONSENT ACT, 9 U.L.A. 453-77 (1988).

In sum, Indiana has a long and distinguished history of accomplishment in health law. The Indiana health care agencies, professionals, and institutions, as well as their attorneys have a tradition of innovation, leadership and excellence. It is no wonder that the Indiana judiciary has responded with similar leadership in tackling the important legal issues facing the health care system today.

II. Three Exemplary Cases

The authors have selected three cases which demonstrate the important tradition of the Indiana judiciary in defining the physician-patient relationship and the contours of that relationship. The first case, *Hurley v. Eddingfield*,[31] dates from the turn of the century and defines the nature of the physician-patient relationship. The second case, *Culbertson v. Mernitz*,[32] addresses physician liability based on the failure to adequately inform the patient about treatment or procedure.[33] More specifically, it addresses Indiana's physician-based standard of informed consent. The third case, *In re Lawrance*,[34] involves a difficult challenge to the physician-patient relationship brought about by the life-extending technologies of modern medicine.

A. Defining the Physician-Patient Relationship

In *Hurley v. Eddingfield*,[35] the Indiana Supreme Court issued a landmark decision which established that the physician-patient relationship is based on contract. The 1901 opinion, written by Judge Baker just three years before his departure for the U.S. Court of Appeals for the Seventh Circuit, defined the contract as one into which both the physician and patient voluntarily enter.

The facts are straightforward.[36] On July 6, 1899, Thomas Burk sought the services of Dr. Eddingfield, a duly licensed physician practicing in Montgomery County as well as the Burk's family physician, to attend Mr. Burk's wife, Charlotte Burk, in the delivery of their child. Although Dr. Eddingfield had no other pressing matters and there were no other available physicians, he refused to assist Mrs. Burk. Charlotte Burk and her baby died due to complications during

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31. 59 N.E. 1058 (Ind. 1901).

32. 602 N.E.2d 98 (Ind. 1992).

33. Another body of law beyond the scope of this Article dealing with the physician-patient relationship gone awry is the law of fraudulent concealment. *See, e.g.*, Hughes v. Glaese, 659 N.E.2d 516 (Ind. 1995); Guy v. Schuldt, 138 N.E.2d 891 (Ind. 1956); Follett v. Davis, 636 N.E.2d 1282 (Ind. Ct. App. 1994); Weinberg v. Bess, 638 N.E.2d 841 (Ind. Ct. App. 1994); Adams v. Luros, 406 N.E.2d 1199 (Ind. Ct. App. 1980); *see also* John C. Render, *Health Care Law, 1994 Survey of Recent Developments in Indiana Law*, 28 Ind. L. Rev. 959, 960-62 (1995).

34. 579 N.E.2d 32 (Ind. 1991).

35. 59 N.E. 1058 (Ind. 1901).

36. Brief for Appellant, Hurley v. Eddingfield, 59 N.E. 1058 (Ind. 1901). *See* Rand E. Rosenblatt et al., Law and the American Health Care System 48 (1997). We are indebted to Rand E. Rosenblatt, Professor of Law at the School of Law, Rutgers University of New Jersey, Camden, for bringing this brief to our attention.

the birth process.

Mrs. Burk's estate sued Dr. Eddingfield for $10,000 in damages for the wrongful death of Mrs. Burk.[37] The court sustained Dr. Eddingfield's demurrer to the complaint.[38] Judge Baker affirmed the Montgomery Circuit Court in a clear, brief, and controversial opinion.[39]

The issue, Judge Baker contended, was the defendant's "refusal to enter into a contract of employment."[40] Judge Baker also explored the implications of state licensure on a doctor's obligations toward those in need of medical care and concluded: "In obtaining the State's license (permission) to practice medicine, the State does not require, and the licensee does not engage, that he will practice at all or on other terms than he may choose to accept."[41]

Judge Baker's decision has generated considerable commentary over the years, including articles in notable law reviews,[42] and it is also included in leading health law textbooks.[43] One well-known commentator on the law of medical malpractice illuminates the *Hurley* case's national prominence and reiterates its importance in delineating the law of the physician-patient relationship:

> The classic case in this area is *Hurley v. Eddingfield*, decided in 1901 by the Supreme Court of Indiana. . . . [T]he court pointed out that the physician-patient contractual relationship is one depending on assent of both parties and that a license to practice medicine does not compel a physician to contract against his will. [Doctors have] the right to refuse to see [a] patient and [are] not therefore liable for the patient's death.[44]

This case does represent a seemingly stark and harsh statement of a physician's obligation to a potential patient. It seems especially harsh given its support of the elective nature of the physician-patient relationship, especially in emergency situations. Yet the law does impose considerable obligations on physicians once the physician-patient relationship commences. It seems only fair that physicians have control over whether they enter that relationship with all of its attendant obligations. Perhaps ethics rather than law is the better instrument to define the physician's moral obligation toward individuals in need of medical treatment. It is noteworthy that the American Medical Association's Code of

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37. *Hurley*, 59 N.E. at 1058.

38. *Id.*

39. *Id.*

40. *Id.*

41. *Id.*

42. *See, e.g.*, Melvin A. Eisenberg, *The Bargain Principle and Its Limits*, 95 HARV. L. REV. 741, 755 & n.45 (1982); Leonard S. Powers, *Hospital Emergency Service and the Open Door,* 66 MICH. L. REV. 1455, 1480 & n.95 (1968); Rand E. Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach,* 88 YALE L.J. 243, 248 & n.13 (1978); Graham Hughes, *Criminal Omissions*, 67 YALE L.J. 590, 632 & n.148 (1957).

43. *See, e.g.*, GEORGE J. ANNAS ET AL., AMERICAN HEALTH LAW 45 (1990); WALTER WADLINGTON ET AL., LAW AND MEDICINE 102, 322, 363 (1980).

44. ANGELA RODDEY HOLDER, MEDICAL MALPRACTICE LAW 7 (1975).

Ethics enunciates a similar vision of the contractual nature of the physician-patient relationship from a legal perspective, but imposes additional obligations on physicians in that relationship as a matter of professional ethics.[45]

B. The Physician-Patient Relationship Gone Awry— Informed Consent in Medical Liability Cases

The physician-patient relationship, while contractual in nature, also has associated duties in tort. Specifically, there is the general duty of care under the law of negligence. The *Restatement (Second) of Torts* defines negligence as "conduct which falls below the standard of care established by law for the protection of others against unreasonable risk of harm."[46]

In addition, the law of negligence imposes an additional duty on physicians to accord their patients sufficient information about proposed medical treatments to enable patients to give informed consent.[47] The doctrine was first articulated by Justice Cardozo and was based on his observation that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body."[48] The doctrine of informed consent arises from the patient's right of self-determination.[49] It requires physicians to provide information to the patient on the nature and the purpose of the procedure or treatment as well as its risks and alternatives.[50]

Indiana adopted the physician-based standard of informed consent in *Culbertson v. Mernitz.*[51] Justice Krahulik wrote the notable opinion ninety-one years after *Hurley v. Eddingfield.*

Patty Jo Culbertson consulted Dr. Mernitz for some troubling gynecological problems. Dr. Mernitz recommended and performed two surgical procedures. Unsatisfied with the results and treatment, Mrs. Culbertson sought another physician's care. Ultimately, according to Mrs. Culbertson, she had to undergo a complete hysterectomy as a result of the two procedures that Dr. Mernitz had performed.

Mrs. Culbertson sued Dr. Mernitz on several medical malpractice theories,

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45. COUNCIL OF ETHICAL & JUD. AFFAIRS, AMA, CODE OF MEDICAL ETHICS §§ 9.06, 9.12 (1996-97 ed.).

46. RESTATEMENT (SECOND) OF TORTS § 282 (1977).

47. BARRY R. FURROW ET AL., HEALTH LAW §§ 6-9 to 6-18 (1995). *See generally* RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT (1986).

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

49. FADEN & BEAUCHAMP, *supra* note 47, at 9, 33; FURROW, *supra* note 47, § 6-9; 1 PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBS. IN MED. & BIOMED. & BEHAV. RES., MAKING HEALTH CARE DECISIONS 2-4 (1982); Marjorie Maguire Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 220 & n.13 (1985).

50. FADEN & BEAUCHAMP, *supra* note 47, at 252. *See* COUNCIL OF ETHICAL & JUD. AFFAIRS, AMA, CODE OF MEDICAL ETHICS § 8.08 (1994 ed.); Anthony Szczygiel, *Beyond Informed Consent*, 21 OHIO N.U. L. REV. 171, 184 (1994).

51. 602 N.E.2d 98 (Ind. 1992).

including informed consent.[52] She asserted that Dr. Mernitz "failed to inform her of the alternatives to the surgery and the inherent risks and complications of the surgery."[53] She proceeded through the medical review panel, as required by Indiana's medical malpractice statute,[54] without success.[55] The Fulton Circuit Court granted summary judgment for the defendant on all claims.[56] The Indiana Court of Appeals reversed in part,[57] because it determined that a lack of informed consent claim did not require expert medical testimony.[58]

On transfer, the Indiana Supreme Court held that "except in those cases where deviation from the standard of care is a matter commonly known by lay persons, expert medical testimony is necessary to establish whether a physician has or has not complied with the standard of a reasonably prudent physician."[59] In this holding, the Indiana Supreme Court clearly adopts a physician-based standard for determining informed consent.

But the court was by no means united in its decision. Justice Krahulik was joined by Chief Justice Shepard and Justice Givan. Justice Dickson wrote a spirited dissent which Justice DeBruler joined.

The doctrine of informed consent has generated considerable debate, and *Culbertson* reflects that debate. The reason for the debate is the doctrine's troubling nature. Liability based on informed consent is often imposed even when liability based on negligent performance of the medical care in question is not warranted. From the physician's perspective, liability is based on factors, such as the outcome of future events, beyond the control of the physician. The patient, on the other hand, lives with a bad result that might have been avoided had the physician provided better information on which to base decisions about medical treatment. But then, the physician counters, will a patient, in retrospect, ever have had enough information if the outcome is bad.

It is no surprise that state courts over the years have adopted two approaches to determining whether patients have given informed consent. One approach is a physician-oriented standard that focuses on what a prudent physician would have done in like or similar circumstances regarding advising the patient about a risk inherent in a proposed procedure.[60] The second approach is a patient-oriented standard that focuses on what a prudent patient would have needed to know regarding a given risk.[61]

Operationally, the different standards impose different requirements for the requisite expert testimony to establish informed consent. With the prudent

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52. *Id.* at 99.
53. *Id.*
54. IND. CODE § 27-12-8-4 (1993).
55. *Culbertson*, 602 N.E. 2d at 99.
56. *Id.*
57. *Id.* (citing Culbertson v. Mernitz, 591 N.E.2d 1040, 1042 (Ind. Ct. App. 1992)).
58. *Id.* at 99-100.
59. *Id.* at 104.
60. FURROW, *supra* note 47, § 6-10(b).
61. *Id.* § 6-10(a).

physician standard, expert testimony is required to establish what a reasonable physician would have done in similar circumstances.[62] In the prudent patient standard, beginning with the seminal cases of *Cobbs v. Grant*[63] and *Canterbury v. Spence,*[64] the plaintiff need not introduce expert testimony once the existence of the risk is established, and the jury can determine if adequate information was given for informed consent.[65]

It is with this understanding of the problematic nature of the informed consent doctrine, that one comes to appreciate both the majority and dissenting opinions in *Culbertson v. Mernitz.*

In the majority opinion, Justice Krahulik comes down on the side of the physician and requires the plaintiff to present expert testimony on what information a reasonably prudent physician would have offered in the same situation. Justice Krahulik reiterates that this standard was well established in Indiana and other jurisdictions prior to the early 1970s when "two cases on the opposite coasts carved out an additional exception to the requirement of expert medical testimony in the area of 'informed consent'"—*Cobbs v. Grant* and *Canterbury v. Spence.*[66]

After reviewing informed consent in Indiana jurisprudence,[67] Justice Krahulik offers a perspective on the practical problem of the physician in the informed consent situation:

> From a physician's viewpoint, he should not be called upon to be a "mind reader" with the ability to peer into the brain of a prudent patient to determine what such patient "needs to know," but should simply be called upon to discuss medical facts and recommendations with the patient as a reasonably prudent physician would.[68]

Justice Krahulik, not unmindful of the patient's important interest in self-determination, comments further: "the physician should be required to give the patient sufficient information to enable the patient to reasonably exercise the patient's right of self-decision in a knowledgeable manner."[69] Further, he observes, that patients do not want the medical profession "to determine in a paternalistic manner what the patient should or should not be told concerning the course of treatment."[70]

Justice Krahulik also recognized that the medical profession's own ethical standards on informed consent had become more sensitive to the importance of patient autonomy in decision-making about medical care. He quotes the standard

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62. *Id.* § 6-10(b).
63. 502 P.2d 1 (Cal. 1972).
64. 464 F.2d 772 (D.C. Cir. 1972).
65. FURROW, *supra* note 47, § 6-10(a).
66. Culbertson, 602 N.E.2d at 100.
67. *Id.* at 101-04.
68. *Id.* at 103.
69. *Id.* at 104.
70. *Id.*

on informed consent from the *1992 Code of Medical Ethics Current Opinions* prepared by the Council on Ethical and Judicial Affairs of the American Medical Association: "The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice."[71] This standard goes on to state the physician's obligation to "present the medical facts accurately" and to "make recommendations for management in accordance with good medical practice." [72] The standard also recognizes that reasonable patients "should not be expected to act uniformly, even under similar circumstances, in agreeing to or refusing treatment."[73]

In his thoughtful dissent, Justice Dickson comes down on the side of the patient.[74] He places great emphasis on the value of patient autonomy as paramount in resolving the informed consent dilemma. He recalls that the court's decision in the case, *In re Lawrance*, had recognized "a commitment to patient self-determination."[75] He goes on to assert that "informed consent is a requisite component of the doctor-patient relationship, attributable in part to the relative lack of parity in that relationship."[76]

Justice Dickson recognizes that the real nub of the informed consent dilemma and the basis of the conflict between prevailing standards is the "disagreement concerning the role of expert witnesses in determining whether the informed consent of the patient has been obtained."[77] With respect to the nature of testimony needed, Justice Dickson nicely states the applicable rule for the prudent patient standard: "while medical expertise would be required to identify the risks of the proposed treatment and non-treatment, the fact finder needs no expert guidance to determine the materiality of a particular risk to a patient."[78] Justice Dickson then lays out the contours of material risk, quoting extensively from *Canterbury v. Spence*.[79]

Further, Justice Dickson rejects the majority's view that the relevant ethical commands of the medical profession adequately address the problem of informed consent. Specifically, Justice Dickson maintains that the AMA standard did not articulate useful parameters to guide physicians on the extent to which risks must be disclosed to patients.[80] However, he points out that this deficiency is "understandable" because the extent of disclosure is really a "non-medical

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71. *Id.* at 103-04 (quoting COUNCIL ON ETHICAL & JUD. AFFAIRS, AMA, 1992 CODE OF MEDICAL ETHICS CURRENT OPINIONS (1992)).

72. *Id.*

73. *Id.*

74. *Id.* at 104 (Dickson, J., dissenting).

75. 579 N.E.2d 32 (Ind. 1991).

76. *Culbertson,* 602 N.E.2d at 105 (Dickson, J., dissenting) (citing Cobbs v. Grant, 502 P.2d 1, 9 (Cal. 1972)).

77. *Id.* at 105.

78. *Id.*

79. *Id.* at 105-06.

80. *Id* at 106.

determination."[81] Justice Dickson concludes: "It is only from the perspective of the ordinary person that a fact-finder can realistically determine how much information is 'enough' for the ordinary reasonable patient to make an informed decision."[82]

Justice Dickson is not unmindful of the dilemma the informed consent situation placed on physicians in requiring a physician "to speculate as to what a hypothetical reasonable patient would 'need to know.'" However, he is also concerned about "bias" and "protective self-interest" with the prudent physician standard[83] and concludes: "Sympathy for such a physician plight, however, is eclipsed by the fundamental value of patient autonomy and self-determination."[84]

The *Culbertson* case presents two opinions that articulate the two prevailing positions on the highly troublesome informed consent doctrine in an especially skillful and accurate manner. On the one hand—the majority tips the balance in favor of the physician. On the other hand—the dissent would tip the balance in favor of the patient.

Conscientious courts endeavor to avoid dissents and speak with one voice. But dissents are wonderful from the perspective of the law teacher for they show students the essential character of the law. Namely, at its heart and core, the law is rhetoric to be plied by lawyers who make it work for the resolution of their clients' problems—day-by-day, case-by-case. Inevitably, there are always more than two sides to any legal issue.

But only academic lawyers have the luxury of vacillating from side to side on important legal questions. Courts must pick a position and decide—even when the issues are not straightforward and the consequences for the loosing party unfortunate. In those opportunities when the Indiana Supreme Court has been asked to take a position and decide questions in delineating the physician-patient relationship, it has done so with wisdom and sensitivity and has achieved justice.

C. The Physician-Patient Relationship Faces New Challenges

Both *Hurley* and *Culbertson* teach that the physician-patient relationship is one which includes certain duties and obligations on the part of the physician toward the patient. Perhaps the most significant of these duties is that of informing the patient of the risks involved in a proposed medical treatment or procedure so that the patient can reach an informed decision about consenting to that treatment or procedure.

Frequently, however, physicians and other health care providers must treat individuals who lack the capacity to consent. For example, patients who suffer an injury rendering them unconscious cannot consent to treatment. To deal with such situations, various forms of constructive or substituted consent have emerged in

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81. *Id.*
82. *Id.*
83. *Id.*
84. *Id.*

the law.[85] This substituted consent generally allows a surrogate to make medical decisions on behalf of the patient.[86]

In the landmark decision *In re Lawrance*,[87] the Indiana Supreme Court addressed a special form of constructive consent—surrogate decision-making by the parents and siblings of an individual who was never competent to give consent.[88] The opinion, written by Chief Justice Shepard, examines the propriety of surrogate decision-making when the decision will most likely result in the patient's death. *Lawrance* is significant in Indiana health law jurisprudence, because, at the time the court heard the case, it was unclear whether artificially-provided nutrition and hydration constituted medical treatment. It was also unclear whether such treatment could be withdrawn based on the consent of parents as surrogate decision-makers.[89] Also, as discussed below, this decision has been important for other state courts in delineating sound rules to address these issues.[90]

Sue Ann Lawrance, born in 1949, grew normally from birth until age nine when she began to show symptoms of intracranial pressure. Sue Ann underwent a craniotomy, a procedure intended to relieve the pressure on her brain.[91] After undergoing this procedure, Sue Ann suffered permanent brain damage. She was, however, still functional to some degree. Throughout the rest of her childhood and adolescence, she attended special schools and camps for the handicapped. Her condition deteriorated over time.

In 1987, at thirty-eight years of age, Sue Ann fell while attending a camp for the disabled and suffered a subdural hematoma. She underwent a second craniotomy. On July 24, 1987, she entered the Manor House nursing home in Noblesville, Indiana, and she remained in a persistent vegetative state until her death on July 18, 1991. She was forty-two years old at the time of her death.

Before Sue Ann Lawrance died, her condition had deteriorated to the point that she could no longer receive food or water orally. To provide her with sustenance, Sue Ann's caretakers inserted tubes into her stomach to deliver nutrition and hydration. Her doctors predicted that she would remain in this state indefinitely. On March 4, 1991, her parents petitioned the court for permission to

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85. FURROW, *supra* note 47, § 17-16.

86. *Id.*

87. 579 N.E.2d 32 (Ind. 1991).

88. See FURROW, *supra* note 47, § 17-31 for a general discussion regarding never-competent individuals.

89. Vaneeta M. Kumar & Eleanor D. Kinney, *Indiana Lawmakers Face National Health Policy Issues*, 25 IND. L. REV. 1271, 1272 (1992).

90. *See* Susan Busby-Mott, *The Trend Towards Enlightenment: Health Care Decisionmaking in* Lawrance *and* Doe, 25 CONN. L. REV. 1159 (1993); Edward O'Brien, Note, *Refusing Life-Sustaining Treatment: Can We Just Say No?*, 67 NOTRE DAME L. REV. 679 (1992); Recent Case, 105 HARV. L. REV. 1426 (1992).

91. *Lawrance*, 579 N.E.2d at 35. Although the case does not specifically state it, considering their daughter's minor status, it was most likely Sue Ann's parents who consented to the craniotomy.

withdraw their daughter's artificially provided nutrition and hydration.[92] She died of natural causes before the petition wended its way through the courts.[93]

However, after her death, despite the mootness of the case, the Indiana Supreme Court decided to issue an opinion. The court found that the case involved a question of "great public interest,"[94] a well-carved out exception to the mootness doctrine. The court also stated: "[I]rrespective of the death of the patient in this litigation, many Indiana citizens, health care professionals, and health care institutions expect to face the same legal questions in the future."[95] Indiana's approach, which gives great deference to the family's interest in making informed medical treatment choices without state intervention, is consistent with positions advocated by various commentators in this area.[96]

The court addressed two issues of significance to surrogate decision-makers, physicians, and health care treatment facilities. First, the court examined the issue of whether Indiana's Health Care Consent Act (HCCA) applies where the family of a never-competent patient in a persistent vegetative state seeks to withdraw artificially provided nutrition and hydration.[97] The HCCA[98] permitted individuals authorized to make medical treatment decisions for another—surrogate decision-makers—"to provide, withdraw, or withhold medical care necessary to prolong life."[99] The act clearly accorded a surrogate decision-maker the right to withdraw medical care. Therefore, the resolution of the case turned on whether artificially provided nutrition and hydration, i.e., food and water delivered directly to the patient's stomach through tubes, constituted "medical treatment" within the meaning of the HCCA.[100]

The HCCA did provide some guidance on this question. The court determined that the act, by virtue of its definition of "health care," applied to "health care" decisions.[101] Specifically, the HCCA defined "health care" as "any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's

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92. *Id.* The petition was filed in Hamilton Superior Court No. 2.

93. *Id.* at 36.

94. *Id.* at 37.

95. *Id.*

96. *See, e.g., The* Saikewicz *Decision, Judges As Physicians*, 298 NEW ENG. J. MED. 508 (1978) (arguing that the court should not involve itself in private decisions between families of incompetent patients and their physicians); Task Force on Ethics of the Society of Critical Care Medicine, *Consensus Report on Ethics of Foregoing Life-Sustaining Treatments in the Critically Ill*, 18 CRITICAL CARE MED. 1435-39 (1990) (arguing that judicial intervention should be a last resort).

97. *Lawrance*, 579 N.E.2d at 38-41.

98. Act of Apr. 30, 1987, No. 207, 1987 Ind. Acts 2340 (codified as amended at IND. CODE §§ 16-8-12-1 to -13 (1988 & Supp. 1992) (repealed 1993) (current version at IND. CODE §§ 16-36-1-1 to -14 (1993)).

99. IND. CODE. § 16-8-12-11(a) (Supp. 1992) (repealed 1993).

100. *See* Kathleen M. Anderson, Note, *A Medical-Legal Dilemma: When Can "Inappropriate" Nutrition and Hydration Be Removed in Indiana?*, 67 IND. L.J. 479, 500 (1992).

101. *Lawrance*, 579 N.E.2d at 40.

physical or mental condition."[102] However, the HCCA itself did not address the question of whether artificial nutrition and hydration was a "treatment" under the act. If it did, the plain language of the HCCA would permit a surrogate decision-maker to consent to the withdrawal of artificial nutrition and hydration.

The court, looking to the Indiana medical community, Indiana statutory law and courts in other jurisdictions, concluded that there was no substantial difference between artificial nutrition and hydration and any other medical treatment.[103] Interestingly, this conclusion is consistent with other positions advanced by the Hastings Center [104] and the American Medical Association.[105]

The court reiterated Indiana's commitment to a patient's right of self-determination regarding decision-making in medical situations.[106] The right to consent to a course of treatment, the court determined, necessarily includes the right to refuse a course of treatment.[107]

The court noted that a patient's autonomy does not end when the patient becomes incompetent, but rather the power to make decisions about health care shifts to the family.[108] The court concluded that "artificial nutrition and hydration is treatment that a competent patient can accept or refuse, that the family of an incompetent patient can accept or refuse it on behalf of the patient, and that the procedures of the HCCA apply to such decisions."[109]

The court next addressed the question of whether court proceedings were necessary to implement the surrogate's decision to withdraw nutrition and hydration.[110] The court found that the HCCA was designed to avoid court proceedings, and that with such a design, the legislature had signaled its clear intent to favor the decision of family-member surrogates over decisions arrived at through judicial intervention.[111] The court wrote that the court system should "become involved only when no one is available to make decisions for a patient or when there are disagreements."[112] The court concluded that court proceedings were not necessary for the Lawrance family to make health care decisions for their

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102. *Id.* at 38.

103. *Id.*

104. *See* THE HASTINGS CENTER, GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND THE CARE OF THE DYING 59 (1987) (concluding that standards for withdrawal of artificial nutrition and hydration are essentially the same as other forms of medical treatment).

105. *See* COUNCIL OF ETHICAL AND JUD. AFFAIRS, AMA, CODE OF MEDICAL ETHICS § 2.20 (1996-97 ed.) (concluding that patient autonomy includes the decision to forgo life-sustaining treatment which may include artificial nutrition and hydration, and if the patient is not competent to make this decision a surrogate may make the decision for the incompetent patient).

106. *Lawrance,* 579 N.E.2d at 38-39 (citing the Indiana Constitution, the common law, and several statutes in support of its decision).

107. *Id.* at 39.

108. *Id.*

109. *Id.* at 41.

110. *Id.* at 41-44.

111. *Id.* at 41-42.

112. *Id.* at 42.

daughter, and that, in the future, health care providers could rely on the decision of surrogate decision-makers to withdraw life sustaining treatment in similar circumstances.[113]

Through *Lawrance*, Indiana adopted the family-based model of decision-making for incompetent patients who have left no or inadequate advance directives.[114] This model allows the family of a never-competent patient to make treatment choices with the assistance of a family physician without the need for judicial intervention.[115] It is also important to note that the court dismissed the emergency guardianship statute as inapplicable to this case.[116] The court asserted that the legislature did not intend to permit strangers to litigate family decisions.[117] In so doing, the court reiterated its support for the private nature of medical decisions which should be made between the physician and the incompetent patient's family. This excludes uninterested (in a legal sense) third parties and the court system from intruding unnecessarily into the private decisions of Indiana's citizens.

The articulation of the family-based decision-making model in *Lawrance* has received some acclaim. Specifically, one commentator observed that: "[T]he Indiana Supreme Court reclaimed the power of surrogates to make decisions for incompetent patients, setting an example for other states to follow."[118] The case has been touted, not only for its determination that artificial treatment and hydration is a medical treatment which can be removed,[119] but also for its clear support of private medical decision-making.[120]

Yet the *Lawrance* decision has not been without criticism.[121] The major thrust of these critiques is a failure to delineate guidance for families in making decisions. Chief Justice Shepard has responded to this criticism:

> The students who edit the Harvard Law Review thought we had failed in our duty to our citizens. I am not persuaded that families need much guidance from judges on these questions or that a court which purports to provide such guidance won't only embroil families in difficult litigation. Surrounded as they are by legions of legal entanglements already, families would do best to consult their own hearts and consciences. The nation has thrived as families have done that over the generations, and it will probably be the surest path for the years ahead.[122]

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113. *Id.* at 43.

114. See Busby-Mott, *supra* note 90, at 1175-76, for a discussion of the Family-Based Decision Making Model.

115. *Id.* at 1175.

116. *Lawrance*, 579 N.E.2d at 43-44.

117. *Id.* at 44.

118. Busby-Mott, *supra* note 90, at 1222.

119. *Id.* at 1213; Anderson, *supra* note 100, at 494.

120. Busby-Mott, *supra* note 90, at 1225; Kumar & Kinney, *supra* note 89, at 1276.

121. *See generally* O'Brien, *supra* note 90; Recent Case, *supra* note 90.

122. Randall T. Shepard, *Family Decisionmaking and Forgoing Treatment: A Judicial*

What does the case mean to physicians and patients in Indiana? It is clear after the *Lawrance* opinion that the Health Care Consent Act permits the surrogate decision-maker broad authority to decide to withdraw extraordinary artificial means used to sustain life when there is no reasonable hope of recovery from a persistent vegetative state. The *Lawrance* decision also serves as a guide to other states adopting the Uniform Health-Care Consent Act and generally as an attempt to resolve questions of surrogate decision-making.

CONCLUSION

The physician-patient relationship has faced tremendous challenges since the turn of the century and the historic case of *Hurley v. Eddingfield.* Modern medical science has developed highly successful treatments for illness as well as life prolonging technologies. Because of the high cost of these treatments and technologies, public and private health insurance has, with all the attendant efforts of third parties to constrain the escalating cost of medical care, impinged on, although not attenuated, the essential therapeutic relationship between physician and patient. Further, the physician-patient relationship has been challenged by expanded tort liability rules, primarily from the 1960s forward, that impose greater accountability on physicians in their relationships with patients.

The twenty-first century will undoubtedly see increasing challenges for the physician-patient relationship. State courts, including Indiana's, must be ready to assist physicians, patients and the other major players in the health care system in delineating appropriate legal rules to meet these challenges and in defining the new dimensions of the relationship in a sound and just manner.

Perspective, 10 ISSUES L. & MED. 251, 260 (1994) (citation omitted).