Winter 1992

A Medical-Legal Dilemma: When Can "Inappropriate" Nutrition and Hydration be Removed in Indiana?

Kathleen M. Anderson
Indiana University School of Law

Follow this and additional works at: https://www.repository.law.indiana.edu/ilj

Part of the Health Law and Policy Commons, and the Medical Jurisprudence Commons

Recommended Citation
Available at: https://www.repository.law.indiana.edu/ilj/vol67/iss2/10

This Note is brought to you for free and open access by the Maurer Law Journals at Digital Repository @ Maurer Law. It has been accepted for inclusion in Indiana Law Journal by an authorized editor of Digital Repository @ Maurer Law. For more information, please contact kdcogswe@indiana.edu.
A Medical-Legal Dilemma: When Can “Inappropriate” Nutrition and Hydration Be Removed in Indiana?

KATHLEEN M. ANDERSON*

INTRODUCTION

The debate over the withdrawal of life support has focused on the forgoing of artificial nutrition and hydration. For some, providing food and water to any patient fulfills a necessary requirement of both supportive and comfort care. Admittedly, supplying nutrition and hydration is appropriate for most patients. Yet many conclude that when the burden of receiving artificial nutrition and hydration exceeds the benefits, certain critically ill patients should have the option of considering the consequences. In *Cruzan v. Director, Missouri Department of Health,* the Supreme Court supported the position that artificial nutrition and hydration may be considered the same as other medical procedures. The Court then held that a state may constitutionally require clear and convincing evidence of a patient’s wishes before allowing the removal of life support.

The Supreme Court’s approach to artificial nutrition and hydration conforms with the American Medical Association Council on Ethical and

---

* J.D. Candidate, 1992, Indiana University School of Law at Bloomington; B.A., 1989, Hanover College.

I would like to thank Professor Roger Dworkin for his extensive comments on the drafts of this Note. I also wish to express my thanks to Frank D. Byrne, M.D., Richard D. Robinson, Esq., and the Midwest Cardiovascular Research Foundation.


4. E.g., *id.*


6. *id.* The Court assumed that even a competent patient has the constitutional right to refuse life-sustaining treatment. *Id.* at 2852. Whether this assumption will continue and how it may influence the question of life-sustaining treatments, including nutrition and hydration, will be uncertain until a case directly confronts it.

7. *Id.* at 2852.
Judicial Affairs' conclusion that "[l]ife [sustaining] medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration." Most lower courts and most in the medical community have also agreed with this conclusion. 9

Many states approach the problem of medical decision making for an incompetent patient with two statutes—living will statutes and durable power of attorney statutes. Living will statutes allow a competent individual to execute a written statement directing that, in the event she becomes incompetent and terminally ill, life-sustaining treatment may be withheld or withdrawn. 10 Living wills allow individuals to make important health care decisions in advance of their incapacity. 8

8. American Med. A., Current Opinions of the Council on Ethical and Judicial Affairs 13 (1986) ("In treating a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweigh its burdens.").

9. See infra note 76.

decisions prior to incompetency. These prior statements not only give individuals some assurance that they have communicated their wishes, but they also give health care providers and family members an indication of the individual's health care preferences. Living wills may be particularly important when a patient does not have family members that can make health care decisions for her or when family members are in disagreement about health care options. Living wills can thus be valuable health care decision-making tools.

However, while living wills can provide an invaluable indication of an incompetent patient's wishes, limits have been placed on them. Despite what may be termed a medical "consensus" on the issue of artificial nutrition and hydration, many state legislatures differentiate artificial nutrition and hydration from other forms of medical treatment in living will statutes. Most statutes apply only to "life-prolonging procedures" or "life-sustaining treatment." Some states exclude the provision of artificial nutrition and hydration from the definition of a "life-prolonging procedure" or "life-sustaining treatment." When states exclude artificial nutrition and hydration from the definition of life-prolonging procedures, the living will statutes do not authorize the withholding or withdrawal of artificial nutrition and hydration.

Health care durable power of attorney statutes allow surrogate decision makers to make necessary health care decisions when a patient becomes incompetent. For a critique of living wills, see Bopp & Marzen, Cruzan: Facing the Inevitable, 19 Law, Med. & Health Care 37, 47 (1991); Lynn, Why I Don't Have a Living Will, 19 Law, Med. & Health Care 101 (1991).

11. See, e.g., the statutes cited supra note 13.
incompetent. In some respects, health care providers may find surrogate decision maker appointments more helpful and flexible than living will declarations. Incompetency, not terminal illness, triggers the appointments, and surrogate decisions are not limited to life-sustaining treatment. However, these surrogate statutes may not mention artificial nutrition and hydration specifically, and they may indicate that prior state law on the withholding or withdrawal of life support has not been changed.

Indiana treats artificial nutrition and hydration differently than other medical treatments under the Living Wills and Life-Prolonging Procedures Act ("Living Wills Act"). Under the Living Wills Act, a person may execute a directive either to withhold or withdraw life-prolonging procedures or to provide all life-sustaining procedures. However, the Living Wills Act


16. Justice O'Connor noted that "procedures for surrogate decisionmaking . . . may be a valuable additional safeguard of the patient's interest in directing his medical care." Cruzan, 110 S. Ct. at 2858 (O'Connor, J., concurring). But see Bopp & Marzen, supra note 11, at 48 (offering a critique of durable power of attorney for health care statutes).

17. Indiana's Health Care Consent Law is an example of this:

Limitations on applicability and effect of chapter. (a) 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.

IND. CODE ANN. § 16-8-12-11. However, Indiana recently incorporated by reference a definition of "health care" that includes different means of administering artificial nutrition and hydration. IND. CODE ANN. § 30-5-2-4 (Burns Supp. 1991). See infra notes 153-63 and accompanying text.

18. IND. CODE §§ 16-8-11-1 to -22.

19. The Living Wills Act states: "Life-prolonging procedure" defined.—As used in this chapter, "life-prolonging procedure" means any medical procedure, treatment, or intervention that:

(1) Uses mechanical or other artificial means to sustain, restore, or supplant a vital function; and

(2) Serves to prolong the dying process.

"Life-prolonging procedure" does not include the provision of appropriate nutrition and hydration, the administration of medication, or the performance of any medical procedure necessary to provide comfort care or to eliminate pain.

IND. CODE § 16-8-11-4. The Act requires that the Living Will Declaration be "substantially"
does not make clear whether artificial nutrition and hydration may ever be withheld or withdrawn under the Act.

Indiana's Health Care Consent Law ("Consent Law"), a health care durable power of attorney statute, allows health care providers to turn to appointed "health care representatives" or to family members to make health care decisions for incompetent patients. Until recently, it was unclear whether a "health care representative" could authorize the withholding or withdrawal of artificial nutrition and hydration under the Consent Law. However, the Indiana Supreme Court put an end to speculation in In re Lawrance, explaining that "[t]he very broad scope which the legislature gave the [Consent Law] also persuades us that its procedures may be applied to decisions concerning artificial nutrition and hydration...."

This in the following form:

LIVING WILL DECLARATION

Declaration made this ___ day of ___ (month, year). I, ___, being at least eighteen (18) years old and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time I have an incurable injury, disease, or illness certified in writing to be a terminal condition by my attending physician, and my attending physician has determined that my death will occur within a short period of time, and the use of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the provision of appropriate nutrition and hydration and the administration of medication and the performance of any medical procedure necessary to provide me with comfort care or to alleviate pain.

In the absence of my ability to give directions regarding the use of life-prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of the refusal.

I understand the full import of this declaration.
Signed ______________________________

City, County, and State of Residence

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years old.

Witness. ___________________________ Date __________

Witness. ___________________________ Date __________

IND. CODE § 16-8-11-12. See also § 16-8-11-12 for the form of a Life Prolonging Procedures Declaration.

20. IND. CODE ANN. §§ 16-8-12-1 to -13.

21. Id.


24. Id.
concluded that "the administration of artificial nutrition and hydration . . . is medical treatment which can be refused."25 Strengthening the supreme court's position, the newly enacted Power of Attorney Act,26 incorporated by reference into the Health Care Consent Law, clarifies the Consent Law's broad definition of "health care."27 "Health care" includes "nutrition and hydration through intravenous, endotracheal, or nasogastric tubes."28 Indiana thus faces two health care statutes, the Living Wills Act and the Health Care Consent Law, that may conflict with each other.

This Note focuses on one general question: May artificial nutrition and hydration ever be withheld or withdrawn from an incompetent patient under the Indiana Living Wills Act? The answer to this general question lies in the resolution of three sub-issues: (1) What is "appropriate nutrition and hydration" under the Living Wills Act? (2) May a "health care representative" under the Health Care Consent Law authorize the removal of appropriate artificial nutrition and hydration that could not be removed under the Living Wills Act? (3) How do the Living Wills Act and the Consent Law interact on the subject of artificial nutrition and hydration?

A reading of "life-prolonging procedures" under the Indiana Living Wills Act should allow the withholding or withdrawal of artificial nutrition and hydration when they are not medically appropriate. Physicians can turn to health care representatives under the Consent Law when questions about the removal of artificial nutrition and hydration arise. A reading of the two statutes should yield a consistent result. If the artificial nutrition and hydration cannot be removed under the Living Wills Act, then what may

25. Id.
26. IND. CODE ANN. §§ 30-5-1-1 to 30-5-10-4 (Burns Supp. 1991); see also IND. CODE ANN. § 16-8-12-13.
27. The Consent Law defines "health care" as "any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition." IND. CODE ANN. § 16-8-12-1. Section 16 of the new Power of Attorney Act reads:
If the attorney in fact has the authority to consent to or refuse health care under section 16(2) [IC § 30-5-5-16(2)] of this chapter, the attorney in fact may be empowered to ask, in the name of the principal, for health care to be withdrawn or withheld when it is not beneficial, or when any benefit is outweighed by the demands of the treatment and death may result. To empower the attorney in fact to act under this section, the following language must be included in an appointment under IC 16-8-12 [Health Care Consent Law] in substantially the same form set forth below:
I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time, based on my previously expressed preferences and the diagnosis and prognosis, my health care representative is satisfied that certain health care is not or would not be beneficial or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.
be done by a health care representative cannot be done by the individual herself under her living will.

Part I of this Note examines the background of withholding and withdrawing life-sustaining treatment generally and approaches the clinical and policy responses to the removal of artificial nutrition and hydration. Part II discusses the judicial and legislative responses to the removal of artificial nutrition and hydration, focusing on Indiana's response. Part III deals with the questions raised by the Indiana Living Wills and Life-Prolonging Procedures Act and Health Care Consent Law and presents a consistent interpretation of the two statutes.

I. BACKGROUND

A. The Withholding or Withdrawal of Life Support Generally

Historically, most people died of diseases or health conditions that progressed rapidly and left little opportunity for long-term maintenance. Today at least eighty percent of Americans die in hospitals and long-term health care institutions, where medical technology can sustain them longer than ever before. In this context, decisions to withhold or withdraw life support occur frequently. Unfortunately, many terminally ill patients are unable to participate in the discussion of life support options, including options that some patients would consider unduly burdensome.

Frequently, patients, families, and health care providers must make decisions about mechanical ventilators, dialysis, cardiopulmonary resuscitation, balloon pumps, intrusive palliative procedures, pacemakers, vasopressors,

29. See generally Capron, Historical Overview: Law and Public Perceptions, in By No Extraordinary Means, supra note 3, at 11.

30. REPORT OF THE PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 16-18 (1983) [hereinafter PRESIDENT'S COMM'N]. Heart disease, cancer, cerebrovascular disease, and other conditions which develop relatively slowly have replaced communicable diseases as leading causes of death. Id. at 16.


32. This conclusion is supported by a study conducted at two teaching hospitals of the University of California at San Francisco. The researchers concluded that, although life-sustaining care was withheld or withdrawn infrequently in the intensive care unit, the decisions precipitated approximately half of the deaths in the intensive care units of the hospitals studied. Smedira, Evans, Grais, Cohen, Lo, Cooke, Schechter, Fink, Epstein-Jaffe, May & Luce, Withholding and Withdrawal of Life Support from the Critically Ill, 322 NEW ENG. J. MED. 309, 309 (1990).

33. PRESIDENT'S COMM'N, supra note 30, at 120-26; Brock, Taking Human Life, 95 ETHICS 851, 855 (1985).
blood, antibiotics, and insulin. Since In re Quinlan\(^3\) in 1976, courts have articulated critically ill patients’ rights to forego life-sustaining treatment in different situations. Courts generally agree that life support may be withheld or withdrawn under appropriate circumstances.\(^4\)

### B. The Withholding or Withdrawal of Artificial Nutrition and Hydration

While the withholding or withdrawal of certain types of medical care now takes place practically unquestioned,\(^5\) the removal of artificial nutrition and hydration may disturb some individuals.\(^6\) Some view the termination of nutrition and hydration, even if artificially provided, differently than the termination of other medical procedures. Nevertheless, some medical situations demand that decisions regarding the provision of nutrition and hydration be made.\(^7\)

#### 1. The Methods and Risks of Providing Artificial Nutrition and Hydration

Patients receive artificial nutrition and hydration in various medical contexts. Surgery may require this support for a short period of time. Long-

---


37. The removal of the mechanical ventilator from a dying patient no longer troubles most doctors, lawyers, and ethicists. Carson, The Symbolic Significance of Giving to Eat and Drink, in BY NO EXTRAORDINARY MEANS, supra note 3, at 84. The mechanical ventilator was once called a “devilishly efficient instrument” by Paul Ramsey. P. RAMSEY, PATIENT AS PERSON 81 (1970); see also Sprung, Changing Attitudes and Practices in Forgoing Life-Sustaining Treatments, 263 J. A.M.A. 2211 (explaining that removal of life support is no longer seriously questioned but including nutrition and hydration in care that may now be removed).

38. See generally Carson, supra note 37, at 84-88. When other types of support are used in conjunction with artificial nutrition and hydration, the question of life support does not usually focus on the provision of nutrition and hydration.

Some health care providers face the removal of nutrition and hydration with some trepidation. Others will not remove this support at all. See Society of Critical Care Medicine Ethics Task Force, Attitudes of Critical Care Professionals Concerning Forgoing Life-Sustaining Treatments, 17 CRITICAL CARE MED. 589 (1989).

39. The ACCP/SCCM Panel included “parenteral and enteral fluids” and “parenteral and enteral nutrition” in the list of “intensive care therapies that are typically withheld or withdrawn (based on disproportionate burden to patients).” ACCP/SCCM Panel, supra note 34, at 953.
term requirements may result from some physical inability, including an inability to swallow or to utilize nutrients, unconsciousness, or an aversion to or lack of interest in eating. Without the provision of artificial nutrition and hydration to these patients, their chances of recovery could be severely limited.

Health care personnel use a number of means to provide artificial nutrition and hydration to patients. Common means of supplying the requirements include nasogastric tubes, gastrostomy tubes, intravenous lines, and hyperalimentation. Each of these methods carries with it some discomfort and difficulties. A gastrostomy tube is surgically inserted through the abdominal wall directly into the stomach. This tube may “obstruct the intestinal tract, erode and pierce the stomach wall or cause leakage of the stomach’s contents into the abdominal cavity.” Reflux of the stomach’s contents into the lung may lead to pneumonia and may also cause sores and infection. Nasogastric tubes, which are inserted through the nose, throat, and esophagus to the stomach, may cause discomfort, vomiting, irritation, bleeding, and ulceration. Dislodged or incorrectly placed tubes may lead to infection or even death. Other problems include metabolic complications, fluid overload, congestive heart failure, electrolyte imbalance, dehydration, and aspiration-induced pneumonia. Intravenous lines, which supply short-term nutrient and fluid requirements directly into the veins, may cause irritated, infected, or collapsed veins. Finally, hyperalimentation requires surgery and follow-up professional care. While qualified health care professionals usually deliver artificial nutrition and hydration effectively, discomfort and risks accompany each of the procedures.

2. The Consequences of Withholding Nutrition and Hydration

Nonetheless, physicians and commentators debate over the amount of pain that a patient experiences without the provision of nutrition and hydration. Physicians notice that patients who are alert until death naturally

41. Beatty, supra note 1, at 424.
44. Bernard & Forlaw, Complications and Their Prevention in Enteral and Tube Feeding, in CLINICAL NUTRITION 553 (1984); Beatty, supra note 1, at 425.
46. Id.
47. Id.
48. Id.
49. Id.
reduce their intake and may even be puzzled by a lack of hunger or thirst. The discomfort varies among those who do feel hunger and thirst, depending on the individual's particular medical circumstances. However, health care providers can control the amount of pain or discomfort that may occur in the clinical setting, and some argue that this pain may be less than the pain that would occur with the administration of food and water.

3. Medical Approaches to Withholding or Withdrawing Nutrition and Hydration

From a medical perspective, the withholding or withdrawal of artificial nutrition and hydration is permissible, but not required, if they are not beneficial or if the burdens outweigh the benefits. The American Medical Association states: “Life-prolonging medical treatment includes . . . artificially or technologically supplied respiration, nutrition or hydration.” The American Geriatrics Society, the American Academy of Neurology, and the

---

50. Lynn, supra note 3, at 2. See also Heymsfield, Bethel, Ansley, Nixon & Rudman, Enteral Hyperalimentation: An Alternative to Central Venous Hyperalimentation, 90 Annals Internal Med. 63 (1979) (describing the starvation process); Lynn & Childress, Must Patients Always be Given Food and Water?, Hastings Center Rep., Oct. 1983, at 17, 19-20 (for those unable to experience hunger or thirst, the removal will not result in more pain than the termination of other medical treatments); Zerwekh, The Dehydration Question, Nursing, Jan. 1983, at 47, 48 (describing the dehydration process).


54. Zerwekh, supra note 50, at 51.

55. Hastings Center, Guidelines on the Termination of Life-Sustaining Treatment and Care of the Dying 59 (1987); Lynn & Childress, supra note 50; Watts & Cassel, supra note 53, at 241.

56. American Med. A., supra note 8, § 2.18, at 12-13 ("It is not unethical to discontinue all means of life-prolonging medical treatment," including artificial nutrition and hydration, for patients in irreversible comas.).
American Dietetic Association also express the opinion that the provision of food and water may represent an elective procedure like others that sustain life. The President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research “found no particular treatments—including such ‘ordinary’ hospital interventions as parenteral nutrition or hydration, antibiotics, and transfusions—to be universally warranted and thus obligatory for the patient to accept.” Many others see no reason to treat food and water differently than other medical treatments.

4. Opposing Voices: Basic Comfort Care and the Threat of Abuse

Mickey, Steinecker, and Thomasma note that “technology has far out-paced our ability to alter the outcome of terminal diseases.” In some cases, food and water may or may not offer comfort. These commentators perceive the provision of intravenous fluids as a “therapy, analytically just like any other therapy, including open heart surgery, kidney transplants, cancer chemotherapy, and so on.” However, several others have identified reasons for believing that a difference exists between the removal of artificial

57. Executive Board, American Academy of Neurology, Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient, 39 NEUROLOGY 125-26 (1989); AMERICAN NURSES’ A. COMM. ON ETHICS, GUIDELINES ON WITHDRAWING OR WITHHOLDING FOOD AND FLUID (1985-87); American Dietetic A., supra note 51, at 78-85.

58. President’s Comm’, supra note 30, at 90.

59. Brock, Forgoing Life-Sustaining Food and Water: Is it Killing?, in By No Extraordinary Means, supra note 3, at 117 (“[F]orgoing food and water does not fall under any special moral prohibition that would make it in itself morally different than the forgoing of other life-sustaining medical care.”); Lynn & Childress, supra note 50 (“There is no reason to apply a different ethical standard to feeding and hydration.”). See also Curran, Defining Appropriate Medical Care: Providing Nutrients and Hydration for the Dying, 313 NEW ENG. J. MED. 940, 940 (1985); Luce, Ethical Principles in Critical Care, 263 J. A.M.A. 698, 699 (1990) (“[W]ithholding and withdrawing of life support are entirely compatible with the ethical principles of beneficence, nonmalefice, and autonomy. . . . [F]luids and nutrition may be withheld or withdrawn as properly as mechanical ventilation and other sophisticated therapies.”); Luce & Raffin, Withholding and Withdrawal of Life Support from Critically Ill Patients, 94 CHEST 621 (1984); Ruark, Raffin & Stanford U. Med. Center Comm. on Ethics, Initiating and Withdrawing Life Support: Principles and Practice in Adult Medicine, 318 NEW ENG. J. MED. 25 (1988); Steinbrook & Lo, Artificial Feeding—Solid Ground, Not a Slippery Slope, 318 NEW ENG. J. MED. 286, 288 (1988) (“Artificial feedings can be viewed on a level with other medical interventions. . . . It should not be considered a part of ‘ordinary care’ or the routine provision of nursing care and comfort.”). See generally Olins, Feeding Decisions for Incompetent Patients, 34 J. AM. GERIATRIC SOC’Y 313, 314 (1986) (citing sources that support the withholding of nutrition and hydration if the patient rejects them).


61. Id. (“[T]hey found it interesting that others perceived them differently.”). For a study on physicians’ attitudes toward the use of intravenous fluids, see Micetich, Steinecker & Thomasma, Are Intravenous Fluids Morally Required for a Dying Patient?, 143 ARCH. INTERNAL MED. 975 (1983).
They argue that nutrition and hydration serve as basic comfort care for all patients, and they equate the provision of artificial nutrition and hydration with the traditional view of meal times. While the provision of artificial nutrition and hydration usually serves as basic comfort care, it may burden patients. Nevertheless, some commentators have focused upon the symbolic meaning of food and water, arguing that emotions attach to nourishment and feedings that attach to no other type of medical support or treatment. Daniel Callahan once saw nourishment as "the most fundamental of human relationships." According to Carson, "The simple act of offering to allay hunger and to slake the thirst of a dying person is deemed, across time and cultures, to be not only right but good." Recognition of the emotions that attach to food and water may be important, but it should not control situations that have medical guidelines and options. The provision of artificial nutrition and hydration in a medical setting does not deserve the same emotional response as daily requirements received in traditional meals. The mealtime analogy does not apply to the insertion of feeding and hydration tubes.

62. See generally Olins, supra note 59.
63. E.g., Anscobine, Ethical Problems in the Management of Severely Handicapped Children: Commentary 2, 7 J. MED. ETHICS 117 (1981); Callahan, supra note 2. See generally Childress, When Is It Morally Justifiable to Discontinue Medical Nutrition and Hydration, in By No Extraordinary Means, supra note 3, at 72.

A nurse alerted authorities after physicians Nejdi and Barber terminated intravenous nutrition and hydration to a severely brain-damaged patient. See infra notes 98-102 and accompanying text for a description of Barber, 195 Cal. Rptr. 484, 147 Cal. App. 3d 1006. The nurse, who provided information that led to the physicians' indictment, asserted, "Food is an ordinary means. And everyone has a right to ordinary treatment." Paris, Kaiser, Conroy, and the Withdrawal of I.V. Feeding: Killing or Letting Die 1 (unpublished paper), cited in Childress, supra, at 72.

64. See generally Walter, Food and Water: An Ethical Burden, 113 COMMONWEAL 616 (1986).
65. See supra notes 40-54 and accompanying text.
66. Callahan, supra note 2, at 22.
67. Carson, supra note 37, at 85 ("[T]o nourish is to nurse, in the inclusive sense of harboring, as well as feeding. To offer food and water is to tend and to regard.").
68. Id. at 86 ("Such feelings ... should be taken seriously and should affect, but not dictate, our actions in these matters."). See Landsman, Terminating Food and Water: Emerging Legal Rules, in By No Extraordinary Means, supra note 3, at 144 ("To rely upon the symbolism of a treatment in requiring it is to acknowledge that the welfare of the individual being treated is irrelevant . . ."); Walter, supra note 64, at 616:

On one hand, our moral sensibilities seem minimally to require that we offer food and water to those who are defenseless and in need of the basic nutritional elements for physical existence. On the other hand, our heads inquire whether the provision of such nutrition and water is not in the end useless or even burdensome for the patient in [a persistent vegetative state].

69. Carson, supra note 37, at 87 ("Feeding is a reciprocal act. Its symbolic significance resides in the mutuality of giving to eat and drink and of taking food and water. . . . In the absence of this gesture of acceptance [the ability to ingest] the act of feeding is incomplete, useless, arguably elective.").
Even though most commentators support allowing patients to die by removing medical treatment, some of them express reservations about removing artificial nutrition and hydration from a dying patient. They may find it difficult to distinguish between "killing" and "letting die" when artificial nutrition and hydration are removed. 70

Several others conclude that removal should be avoided because of the threat of abuse by health care providers. Daniel Callahan cautions, "[W]hat if caregivers withhold food and water thoughtlessly, carelessly, and incorrectly, thereby causing much suffering and debasing a loyalty and duty to a large number of seriously ill people?" 71 While this is a valid concern, the medical profession holds its members to certain standards, regardless of the type of treatment or support, and health care providers face civil or criminal liability if they behave inappropriately. 72

Critics who rely on the symbolic significance of food and water alone must be distinguished from critics who focus on the practical problems of removal. Visions of a health care provider withholding a plate of food and a glass of water from a patient obscure the reality that feeding and fluid tubes may become a burden that both physicians and patients may wish to terminate. Recognizing artificial nutrition and hydration as medical treatments that patients may refuse along with artificial ventilators and other life support is consistent with the realities of providing artificial nutrition and hydration. 73 In addition, allowing patients to refuse artificial nutrition and hydration fits into a deep tradition of support for personal autonomy. Justice Cardozo, while on the New York Court of Appeals, stated: "Every human being of adult years and sound mind has a right to determine what

---

70. For a critique of the view that there is an absolute duty not to "kill" another, as applied to incompetent dying patients, see Brock, supra note 33, at 855 (characterizing such a duty as restrictive and interfering with a "position of common morality" that a competent patient may refuse treatment).

71. Callahan, Public Policy and the Cessation of Nutrition, in By No Extraordinary Means, supra note 3, at 64. ("[I]n our society we have a solid history of seeing things that were initially introduced as possibilities for choice or discretion turned into matters of mandatory behavior."). Callahan recognizes that the "reasonable argument" is that "on certain occasions, we ought to be allowed to stop nutrition with some patients." Id. at 64.

72. One response to Callahan's concern about abuse in particular cases is to build in safeguards. My interpretation of the Indiana Living Wills Act and Health Care Consent Law, discussed infra notes 170-76 and accompanying text, should not concern him. In addition, the Living Wills Act incorporates a number of safeguards, including requirements of a valid execution of the document and of a "terminal condition" that will result in death within a "short period of time." Ind. Code § 16-8-11-14 (1988). Likewise, the Health Care Consent Law requires that surrogates' decisions not be contrary to patients' instructions and that the physicians look to the patient's best interests, relying on appropriate medical standards. Ind. Code Ann. § 16-8-12-3(b) and § 16-8-12-7(b) (Burns 1990). Immunity from civil and criminal liability does not result unless providers adhere to the terms of the statutes. Ind. Code § 16-8-11-14(d) and Ind. Code Ann. § 16-8-12-9 (Burns 1990). See discussion infra note 171.

73. See supra notes 40-54 and accompanying text.
shall be done with his own body.” Since this oft-quoted statement was made, courts have recognized individuals’ ability to make their own health care decisions, including decisions about life support.

II. LEGAL BACKGROUND: ARTIFICIAL NUTRITION AND HYDRATION

Most courts recognize that the provision of artificial nutrition and hydration may be no different than any other medical treatment. Following the majority of state courts, the Supreme Court in Cruzan v. Director, Missouri Department of Health assumed that a competent individual has a right to refuse life-sustaining treatment and did not treat nutrition and hydration differently. In addition, the Indiana Supreme Court recently

75. See infra notes 89-123 and accompanying text. There have been some recognized limits on individuals’ personal health care decisions. See, e.g., Roe v. Wade, 410 U.S. 113 (1973) (placing certain limits on a woman's right to terminate her pregnancy); Jacobson v. Massachusetts, 197 U.S. 11 (1905) (upholding a law requiring mandatory vaccinations when deemed necessary for public health and safety). Likewise, the right to refuse life-sustaining medical treatment is not absolute. Brophy, 398 Mass. at 432-34, 497 N.E.2d at 634-35 (citing a number of courts that have considered state interests in cases addressing the removal of life support). In addition, many states have prohibitions against suicide. See Smith, All’s Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?, 22 U.C. Davis L. Rev. 275, 291 n.106 (1989) (listing state statutes which make suicide a crime).
77. 110 S. Ct. 2841 (1990).
78. Nancy Cruzan had been in a persistent vegetative state supported by the provision of artificial nutrition and hydration since 1983. On Nancy Cruzan’s behalf, her parents requested that the provision be terminated. Id. at 2844-46. The Supreme Court of Missouri overturned the lower court’s ruling that there was clear and convincing evidence of Nancy Cruzan’s wishes to terminate the nutrition and hydration. Cruzan v. Harmon, 760 S.W.2d 408, 416-17 (Mo. 1988). The Supreme Court, while recognizing that states could require clear and convincing
explicitly recognized that artificial nutrition and hydration may be removed under certain circumstances.79

Despite judicial recognition of artificial nutrition and hydration as medical treatments, several state legislatures have not followed suit. A number of state statutes prohibit the enforcement of directives to remove artificial nutrition and hydration.80 Indiana seems unique in providing in its Living Wills Act that "appropriate nutrition and hydration" are not "life-prolonging procedures."81 Commentators usually include Indiana in the lists of states that do not allow directives to authorize the removal of nutrition and hydration.82 However, careful consideration of the statute leads to the conclusion that Indiana should not be characterized the same as those states that never allow the removal of nutrition and hydration.

In the past few years, some states have considered changing living will statutes to apply to artificial nutrition and hydration.83 This discussion has

---

80. See supra note 10.
82. See, e.g., A. MESEL, supra note 1; Beaty, supra note 1, at 431; Gelfand, Living Will Statutes: The First Decade, 1987 Wis. L. Rev. 737, 750 n.49.
83. Washington's Initiative 119 not only included artificial nutrition and hydration in life-support systems that could be removed, but also proposed to allow competent, terminally ill adults to request assistance in dying. Euthanasia Initiative Goes to Legislature, The Seattle Times, Jan. 30, 1991, at F2; Hammond, After Two Years of Torment, Death Won the Game, Seattle Times, Sept. 7, 1990, at 9. Despite "broad agreement for the principle of doctor-assisted suicide," Washington voters rejected Initiative 119. See J. Gross, The 1991 Election: Euthanasia; Voters Turn Down Mercy Killing Idea, N.Y. Times, Nov. 7, 1991, at B16, col. 1. Voters may have grown "squeamish and doubtful as they looked at the fine print of the legislation." Id. Media coverage of the Cruzan case focused the public's attention on the issue of life support. Even before the Supreme Court announced the Cruzan decision, there was extensive coverage of that case and similar cases. See, e.g., Gibbs, Love and Let Die, Time, Mar. 19, 1990, at 62 (featuring on the cover a stark photograph of Christine Busalacchi, who has been unconscious since 1987, with her feeding tube exposed and her father looking on).
not yet been successful in Indiana. However, the Indiana legislature recently incorporated the new Power of Attorney Act provisions into the Health Care Consent Law, making a health care representative’s ability to make decisions concerning artificial nutrition and hydration clearer. The provisions in the Power of Attorney Act include the provision of artificial nutrition and hydration in the definition of medical treatment. In addition, the recent Lawrance decision, as well as the Cruzan decision, may encourage the Indiana legislature to consider living will legislation that recognizes artificial nutrition and hydration as medical procedures that may be legitimately removed.

Before examining whether artificial nutrition and hydration may ever be withheld or withdrawn under the Living Wills and Life-Prolonging Procedures Act (“Living Wills Act”), consideration of whether they may be removed apart from either the Living Wills Act or the Consent Law proves helpful. Since case law supports the removal of artificial nutrition and hydration even without a living will or the appointment of a health care representative, the question of removal under the statutes becomes clearer.

In the recent In re Lawrance, the Indiana Supreme Court supported the removal of artificial nutrition and hydration under the Consent Law. The Lawrance decision should not come as any surprise. Many other state courts that considered the question helped predict the outcome of such a case in Indiana. Indiana courts had not indicated that they would deal with the question differently.

A. Cases Considering the Removal of Life Support

The first case to address the removal of life support, In re Quinlan, involved a young woman who suffered severe brain damage and entered a...
persistent vegetative state. Her father sought his appointment as guardian with the authority to order the removal of the mechanical respirator that supported Quinlan. The New Jersey Supreme Court recognized a right of privacy grounded in the U.S. Constitution, which would allow the termination of treatment, but concluded that the right was not absolute. The state’s interest in “the preservation and sanctity of human life and defense of the right of the physician to administer medical treatment according to his best judgment . . . weakens and the individual’s right to privacy grows as the degree of bodily invasion increases and the prognosis dims;” in that case the New Jersey court found the state’s interest to be subordinate to the patient’s interest.\textsuperscript{90} The court supported the family’s determination of whether the incompetent patient would exercise her right to refuse treatment under the circumstances.\textsuperscript{91} However, the decision making was subject to certain procedures designed to safeguard the process.\textsuperscript{92}

After Quinlan, courts concentrated on the common law right to refuse treatment, although several courts also considered the constitutional privacy right.\textsuperscript{93} Superintendent of Belchertown State School v. Saikewicz\textsuperscript{94} looked to both a common law right to informed consent and to a constitutional privacy right in a case involving the withdrawal of chemotherapy from a sixty-seven-year-old retarded man with leukemia.\textsuperscript{95} The court concluded that an incompetent individual retains the right to refuse treatment and adopted a “substituted judgment” standard for determining the individual’s wishes.\textsuperscript{96}

\textsuperscript{90} Id. at 41, 355 A.2d at 663-64.

\textsuperscript{91} Id. (“The only practical way to prevent destruction of [her right to privacy] is to permit the guardian and family of Karen to render their best judgment, subject to the qualifications hereinafter stated, as to whether she would exercise [her right] in these circumstances.”).

\textsuperscript{92} The safeguards the court set forth were somewhat elaborate and allowed the physicians and the hospital considerable discretion in the decision to withdraw life support: Upon the concurrence of the guardian and family of Karen, should the responsible attending physicians conclude that there is no reasonable possibility of Karen’s ever emerging from her present comatose condition to a cognitive, sapient state and that the life-support apparatus now being administered to Karen should be discontinued, they shall consult with the hospital “Ethics Committee” or like body of the institution in which Karen is then hospitalized. If that consultative body agrees that there is no reasonable possibility of Karen’s ever emerging from her present comatose condition . . . , the present life-support system may be withdrawn and said action shall be without any civil or criminal liability . . . .

\textsuperscript{93} Cruzan, 110 S. Ct. at 2847; see also L. Tribe, American Constitutional Law § 15-11 (2d ed. 1988).

\textsuperscript{94} 373 Mass. 728, 370 N.E.2d 417 (1977).

\textsuperscript{95} Id.

\textsuperscript{96} Id. The “substituted judgment” standard attempts “to determine with as much accuracy as possible the wants and needs of the individual involved” in order to decide what the person would have decided if he had been competent. Id. at 750, 370 N.E.2d at 430. For a review of the historical development of the substituted judgment standard, see id. at 431.

The court in In re Storar, 52 N.Y.2d 363, 420 N.E.2d 64, cert. denied, 454 U.S. 858 (1981),
The court recognized the state’s interests in the question, noting that interest in the preservation of life was the most important of those discussed, especially when an affliction was curable.97

The first reported case to consider the specific question of the removal of artificial nutrition and hydration did so in the criminal context. In *Barber v. Superior Court*,98 two physicians terminated the provision of intravenous fluids to a patient who had suffered severe brain injury during surgery.99 The magistrate dismissed murder charges against them at the end of the preliminary hearing, concluding that the removal was not “killing.”100 After the trial court ordered the complaint be reinstated, the appellate court reversed. The appellate court determined that the evidence supported the dismissal of the complaint since the removal was not an affirmative act or an unlawful failure to perform a legal duty given the patient’s chances of recovery and the family’s wishes.101 The court stated, “[W]e view the use of an intravenous administration of nourishment and fluid, under the circumstances, as being the same as the use of the respirator or other form of life support equipment.”102

Since *Barber*, courts have allowed the withholding or withdrawal of artificial nutrition and hydration as long as particular safeguards are followed.103 The same court that decided *In re Quinlan*104 addressed artificial nutrition and hydration in *In re Conroy*.105 The New Jersey Supreme Court recognized the “emotional significance” of food but noted that feeding by implanted tubes is a “medical procedur[e] with inherent risks and possible side effects, instituted by skilled health-care providers to compensate for impaired physical functioning.”106 The court determined that “artificial

looking only to the common law informed consent doctrine, turned to a “best interests” approach for a patient who had been incompetent for most of his life. The “best interests” approach looks not to what the patient would have decided, but to what decision would be best for the patient. Since Storar had never been competent, the court concluded that “it [was] unrealistic to attempt to determine whether he would want to continue potentially life prolonging treatment if he were competent.” *Id.* at 380, 420 N.E.2d at 71.

99. *Id.* at 1010-11, 195 Cal. Rptr. at 485-86. The patient’s immediate family supported the removal of the intravenous fluids. *Id.* at 1010, 195 Cal. Rptr. at 485.
100. *Id.* at 1011, 195 Cal. Rptr. at 486.
101. *Id.* at 1016-21, 195 Cal. Rptr. at 489-93.
102. *Id.* at 1016, 195 Cal. Rptr. at 490.
103. See, e.g., *supra* note 92.
104. 70 N.J. 10, 355 A.2d 647.
105. 98 N.J. 321, 486 A.2d 1209 (The court concentrated on a common law right of self-determination.).
106. *Id.* at 373, 486 A.2d at 1236. The court asserted that “the right to self-determination ordinarily outweighs any countervailing state interests, and competent persons generally are permitted to refuse medical treatment, even at the risk of death.” *Id.* at 353, 486 A.2d at 1225. The court continued, “Most of the cases that have held otherwise, unless they involved the interest in protecting innocent third parties, have concerned the patient’s competency to
feeding by means of a nasogastric tube or intravenous infusion can be seen as equivalent to artificial breathing by means of a respirator.  

Following Conroy, in In re Jobes,\footnote{108} the same court allowed the removal of nutrition and hydration according to certain safeguards, explaining that “the right of a patient in an irreversibly vegetative state . . . may be exercised by the patient's family or close friend.”\footnote{109} The Supreme Court of Massachusetts supported the application of the substituted judgment standard to the removal of artificial nutrition and hydration in Brophy v. New England Sinai Hospital.\footnote{110} In Bouvia v. Superior Court,\footnote{111} the California Court of Appeal honored the request of a competent twenty-eight-year-old quadriplegic that the nasogastric tube that supported her be removed.\footnote{112} 

Corbett v. D'Alessandro\footnote{113} permitted the cessation of artificial nutrition and hydration, finding “no reason to differentiate between the multitude of artificial devices that may be available to prolong the moment of death.”\footnote{114} Finally, the more recent case of In re Estate of Greenspan\footnote{115} allowed the discontinuance of artificial nutrition and hydration by a public guardian.\footnote{116} 

These courts have progressively developed an incompetent individual's right to refuse life-sustaining treatment, including artificial nutrition and hydration. The United States Supreme Court in Cruzan v. Director, Missouri Department of Health,\footnote{117} stated, “[F]or the purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.”\footnote{118} It considered the state’s interests—the preservation of life, the safeguarding of the “personal element of this choice,” and the reluctance to make “quality” of life determinations.\footnote{119} The Court stated, “In our view, Missouri has permissibly sought to advance these interests through 

make a rational and considered choice of treatment.” Id. at 353-54, 486 A.2d at 1225. The court then concluded that an incompetent individual’s right to refuse treatment may be exercised by a surrogate decision maker. Id. at 361-68, 486 A.2d at 1229-33.  

107. Id. at 373, 486 A.2d at 1236.  
109. Id. at 420, 529 A.2d at 447.  
111. 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297.  
112. Id.  
113. 487 So. 2d 368.  
114. Id. at 371.  
115. 137 Ill. 2d 1, 558 N.E.2d 1194 (removal allowed despite the fact that the patient executed neither a living will nor appointed a surrogate decision maker).  
116. Id.  
117. 110 S. Ct. 2841. See generally Annas, The Long Dying of Nancy Cruzan, 19 LAW, MED. & HEALTH CARE 52 (1991) (critiquing the Cruzan decision); Bopp & Marzen, supra note 11 (examining the decision and its implications).  
118. Cruzan, 110 S. Ct. at 2852. Justice O'Connor noted: “Accordingly, the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water.” Id. at 2857 (O'Connor, J., concurring).  
119. Id. at 2852-53.
the adoption of a 'clear and convincing' standard of proof to govern such proceedings.'\textsuperscript{1120} The Supreme Court's holding was narrow—merely that a state could require clear and convincing evidence as a "procedural safeguard."\textsuperscript{1121} However, the Court did recognize that it was "not faced in this case with the question of whether a State might be required to defer to the decision of a surrogate if competent and probative evidence had established that the patient herself had expressed a desire that the decision to terminate life-sustaining treatment be made for her by that individual."\textsuperscript{1122}

While it is uncertain how far the Supreme Court would extend an incompetent patient's right to refuse life-sustaining treatment, the Court did affirm important principles of health care decision making, as well as address the question of artificial nutrition and hydration. While the determination of the burden of proof remains a matter for the states to govern, the Court, at a minimum, assumed that the right to refuse treatment exists.\textsuperscript{1123}

\textbf{B. Indiana's Approach to Artificial Nutrition and Hydration}

The courts' progressive development of an individual's right to refuse treatment puts the recent \textit{In re Lawrance} decision in its proper context. Indiana case law, as well, paved the way for the Indiana Supreme Court's approach to nutrition and hydration in \textit{Lawrance}.

A recent Indiana medical malpractice case, \textit{Payne v. Marion General Hospital},\textsuperscript{124} charged a physician with negligence for not consulting the patient before entering a "no code" order\textsuperscript{122} on the patient's chart. The case focused on whether the patient\textsuperscript{126} was competent enough for the physician to have consulted him about the order.\textsuperscript{127} A few hours after the order,

\textsuperscript{1120} Id. at 2853.
\textsuperscript{1121} Id. at 2852.
\textsuperscript{1122} Id. at 2856 n.12. Justice O'Connor noted:

I also write separately to emphasize that the Court does not today decide the issue whether a State must also give effect to the decisions of a surrogate decisionmaker... In my view, such a duty may well be constitutionally required to protect the patient's liberty interest in refusing medical treatment.

\textit{Id.} at 2857 (O'Connor, J., concurring).

\textsuperscript{1123} Id. at 2852.
\textsuperscript{124} 549 N.E.2d 1043 (Ind. Ct. App. 1990). The appellate court dealt with an appeal from a grant of a summary judgment motion in favor of the defendants.

\textsuperscript{125} A "no code" order, which may also be referred to as a "do-not-resuscitate" order or a "no code blue" order, is a designation in a patient's chart that no cardiopulmonary resuscitation is to be given in case of cardiopulmonary arrest. \textit{See Mooney, Deciding Not to Resuscitate Hospital Patients: Medical and Legal Perspectives, 1986 U. Ill. L. Rev. 1025, 1025-26.}

\textsuperscript{126} Payne was a 65-year-old alcoholic who suffered from malnutrition, uremia, hypertension, cardiovascular disease, chronic obstructive lung disease, and other medical problems. \textit{Payne}, 549 N.E.2d at 1044.

\textsuperscript{127} The physician consulted with the patient's sister, who supported the entry of the order after she observed Payne's worsening condition. \textit{Id.}
Payne died; no cardiopulmonary resuscitation was attempted. The appellate court noted that no court had considered a physician’s liability for entering a “no code” order and then directed its attention to cases in various jurisdictions that had dealt with the removal of life support. The court stated that “[t]he patient’s right of self-determination is the sine qua non of the physician’s duty to obtain informed consent.” The court then examined testimony on the patient’s competency presented at the trial, concluding that “genuine issue[s] of fact” existed that required a reversal of the lower court’s grant of summary judgment for the defendant physician and the practice group. Payne thus illustrated Indiana’s support for a patient’s right of self-determination, even though the case did not deal with Indiana statutory law.

Recognizing that artificial nutrition and hydration may be removed without a living will or without the appointment of a surrogate decision maker goes a long way toward answering the question of whether they may be removed under the Indiana Living Wills Act and the Health Care Consent Law. Put simply, it is unreasonable to conclude that what can be done without a living will cannot be done with it. Given the language of the two Indiana statutes and the policy considerations that underlie them, the logical conclusion is that artificial nutrition and hydration may be removed with or without living wills or health care appointments.

While specifically considering the Indiana Health Care Consent Law, the Indiana Supreme Court, in the case of In re Lawrance, examined Indiana constitutional law, Indiana common law, persuasive authority from other states, and the view of the medical community in reaching its decision. The court addressed the question of “whether the parents of a patient in a persistent vegetative state [could] authorize the withdrawal of artificially provided nutrition and hydration from their never-competent daughter.” Sue Ann Lawrance, the patient, was described by the Indiana Supreme Court as a “forty-two-year-old woman who was ‘completely nonverbal, nonambulatory, requiring total care and... only sustained by artificially delivered nutrition and hydration.’” Lawrance died in the course of the appeal, but the supreme court determined that the case fell into a public interest exception to the mootness principle. The court noted:

128. Id. at 1045.
129. Id. at 1046. The court quoted Justice (then Judge) Cardozo: “‘Every human being of adult years and sound mind has the right to determine what shall be done with his own body ... .’” Id. (quoting Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914)).
130. Id. at 1050. The appellate court did not reverse the grant of summary judgment motion as to the hospital. Id. at 1051.
131. See infra discussion at notes 147-63 and accompanying text.
132. Lawrance, 579 N.E.2d at 34.
133. Id. (citing Amended Order on Petition for Authority at 3).
134. Id. at 37.
The public interest at stake is demonstrated in part by the great number of high quality amicus briefs submitted to this Court. These briefs suggest that, irrespective 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.\textsuperscript{135}

The Indiana Supreme Court concluded that the legislature intended the Consent Law to be a "procedural statute."\textsuperscript{136} The court stated that "the act [was] designed to establish procedures for health care decision making without altering the substantive right of patients and their families."\textsuperscript{137} The court then turned to the substantive law of Indiana, explaining that "Indiana common law and statutory law both describe an environment in which patient decision making is a central tenet."\textsuperscript{138}

While the Indiana Supreme Court did not consider the United States Constitution, the court noted that the "common law [had] evolved in a legal culture governed by the Indiana Constitution, which begins by declaring that the liberty of our citizens is inalienable."\textsuperscript{139} According to the court, "[t]he debates of our constitutional convention suggest that those who wrote the constitution believed that liberty included the opportunity to manage one's own life except in those areas yielded up to the body politic."\textsuperscript{140} The supreme court then turned to provisions of the Indiana Living Wills Act, the new Powers of Attorney Act, and the Health Care Consent Law to support its statement that "Indiana's statutes reflect a commitment to patient self-determination."\textsuperscript{141}

Finding a "substantive right of a patient or her representative to refuse life-sustaining medical treatment," the court concluded that "the administration of artificial nutrition and hydration . . . is medical treatment which can be refused."\textsuperscript{142} This determination was supported by "the view of the Indiana medical community; Indiana statutory law, including the [Consent Law]; and persuasive authority from numerous courts across the country."\textsuperscript{143}

\textsuperscript{135} \textit{Id.}.
\textsuperscript{136} \textit{Id.} at 38. The court supported this conclusion by turning to the use of the word "affect" in Indiana Code section 16-8-12-11(a) and to the uniform act upon which the Consent Law was based. \textit{Id.} See \textit{MODEL HEALTH-CARE CONSENT ACT Prefatory Note, 9 U.L.A. 453 (1988).}
\textsuperscript{137} \textit{Lawrance}, 579 N.E.2d at 38.
\textsuperscript{139} \textit{Id.} at 39 (looking to \textit{IND. CONST. art. I, § 1}).
\textsuperscript{140} \textit{Id.}
\textsuperscript{141} \textit{Id.}
\textsuperscript{142} \textit{Id.}
\textsuperscript{143} \textit{Id.} The court cited the Indiana State Medical Association statement of the American Medical Association Council on Ethical and Judicial Affairs' opinion. \textit{Id.} at 39-40. The court then stated that "[t]he very broad scope which the legislature gave the [Consent Law] also
The supreme court determined that the Consent Law was "designed to resolve health care decisions without a need for court proceedings." The court also concluded that the lower court erred in appointing a temporary limited guardian for Lawrance under Indiana Code § 29-3-3-4, since her family appeared to have the authority to act in the circumstances.

*In re Lawrance* has broad scope regarding both the ability to refuse life-sustaining treatment and artificial nutrition and hydration in general. Given the scope of *Lawrance*, the approach of Indiana's Living Wills and Life Prolonging Procedures Act seems particularly restrictive regarding artificial nutrition and hydration.

**C. Indiana's Living Wills and Life-Prolonging Procedures Act**

One approach to the Living Wills Act assumes that the Act does not grant any right which patients did not previously have. This is clearly supported by case law from other jurisdictions and may be inferred from *Payne v. Marion General Hospital* and from *In re Lawrance*. Indiana Code § 16-8-11-1 outlines Indiana's policy: "Competent adults have the right to control the decisions relating to their own medical care, including..."
the decisions to have medical or surgical means or procedures calculated to prolong their lives provided, withheld, or withdrawn." The statute allows an individual to execute a "living will" indicating a desire not to have life-prolonging procedures provided in the event of incompetency and a terminal illness from which death will occur within a short period of time.\textsuperscript{151} The definition of a "life-prolonging procedure" explicitly excludes the provision of "appropriate nutrition and hydration, the administration of medication, or the performance of any medical procedure necessary to provide comfort care or alleviate pain."\textsuperscript{152}

\section*{D. The Indiana Health Care Consent Law}

The Indiana Health Care Consent Law ("Consent Law")\textsuperscript{153} allows a representative to make health care decisions for an incompetent patient. The law defines "health care" as "any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition."\textsuperscript{154} The Consent Law then states that "[a]n individual otherwise authorized under th[e] 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"\textsuperscript{155} or if the patient left contrary instructions.\textsuperscript{156} Those "otherwise authorized" include those individuals appointed in a writing under section 16-8-12-6 or by a family member or guardian under section 16-8-12-4.\textsuperscript{157} Like the Living Wills Act,\textsuperscript{158} 151. In the alternative, an individual may execute a "life-prolonging procedure declaration," which requests the provision of all life-prolonging procedures under the same circumstance. \textit{Ind. Code} § 16-8-11-12 (1988).

One purpose of the Living Will Act is to free physicians from liability if they follow the terms of the Act. \textit{Ind. Code} § 16-8-11-14(c)-(d) (1988). The Act requires that the declarant be at least eighteen years of age, that the declaration be in writing, and that it be witnessed by two individuals. \textit{Ind. Code} § 16-8-11-11 (1990 Supp.). The witnesses may not be a parent, spouse or child of the declarant, anyone entitled to any part of the declarant's estate nor anyone directly responsible for the declarant's medical care. \textit{Id.} The physician must certify in writing that the patient is a "qualified" patient under the Act—that is, that the patient has a terminal condition and that death will occur from the terminal condition whether or not life-prolonging procedures are used. \textit{Ind. Code} § 16-8-11-14 (1988). A living wills declaration is not binding upon the physician, \textit{Ind. Code} § 16-8-11-11(f), although there is an obligation to transfer the patient to another physician who will follow the declaration's terms if it is determined that the patient is "qualified," \textit{Ind. Code} § 16-8-11-14(e)-(f).

\textsuperscript{152} \textit{Ind. Code} § 16-8-11-4.
\textsuperscript{153} \textit{Ind. Code Ann.} §§ 16-8-12-1 to -13 (Burns 1990 & 1991 Supp.).
\textsuperscript{154} \textit{Ind. Code Ann.} § 16-8-12-1(2).
\textsuperscript{155} \textit{Ind. Code Ann.} § 16-8-12-3(a).
\textsuperscript{156} \textit{Ind. Code Ann.} § 16-8-12-3(6). This part of the statute supports the conclusion that the substituted judgment standard should be implemented when there is sufficient evidence. However, \textit{Ind. Code Ann.} § 16-8-12-6(h)(1) suggests that the best interest approach should be used.
\textsuperscript{157} Family members listed are spouses, parents, adult children, or adult siblings. \textit{Ind. Code Ann.} § 16-8-12-4(2). A religious superior may also make health care decisions if no one else is available. \textit{Ind. Code Ann.} § 16-8-12-4(3).
the Health Care Consent Law offers health care providers exemption from liability if they follow the Consent Law in good faith.\textsuperscript{158}

If the statute said nothing more, no question would arise whether a health care representative or family member could authorize the withholding or withdrawal of artificial nutrition and hydration. Artificial nutrition and hydration would be "care" used "to maintain" the patient's "physical . . . condition."\textsuperscript{159} However, the chapter notes that it "does not affect Indiana law concerning an individual's authorization to make a health care decision for an individual or another individual, or to provide, withdraw, or withhold medical care necessary to prolong or sustain life."\textsuperscript{160} Based on this provision, some have suggested that the Consent Law was never intended for anything but routine health care decisions.\textsuperscript{161} \textit{In re Lawrance}\textsuperscript{162} rejects this conclusion. In addition, the newly enacted Power of Attorney Act that is incorporated into the Consent Law includes the provision of artificial nutrition and hydration in its definition of "health care."\textsuperscript{163}

III. CONCLUSIONS BASED UPON POSSIBLE INTERPRETATIONS OF THE ACTS

A. Indiana's Living Wills and Life-Prolonging Procedures Act: What is "Appropriate Nutrition and Hydration?"

No significant legislative history exists concerning the passage of the Indiana Living Wills and Life-Prolonging Procedures Act ("Living Wills Act"). However, the Living Wills Act did not go unnoticed by the media.

\textsuperscript{158} IND. CODE ANN. § 16-8-12-9.
\textsuperscript{159} IND. CODE ANN. § 16-8-12-1.
\textsuperscript{160} IND. CODE ANN. § 16-8-12-11(a). See Thompson, Indiana Health Care Consent Law: A Guiding Light for the Health Care Providers, 21 IND. L. REV. 181, 199-200 (1988) (reaching the conclusion that the Health Care Consent Law was not intended to alter the Living Wills Act).
\textsuperscript{161} E.g., Thompson, supra note 160, at 199-200; see Brief of Indiana State Representatives Donald T. Nelson and Jesse Villapando as Amici Curiae at 4, Lawrance, 579 N.E.2d at 32 (arguing that the Consent Law was "not intended to apply to cases involving life-sustaining nutrition and hydration"). Those who argue that the Consent Law was not intended to alter existing substantive Indiana law turn to the Model Act upon which Indiana's law was derived. See IND. CODE ANN. § 16-8-12-11(a) and MODEL HEALTH-CARE CONSENT ACT § 11, 9 U.L.A. at 470. The comment to section 11 of the Model Act states:
This Act is narrow in scope. It is not concerned with the narrow standard of care required of health-care providers. It is not concerned with whether, how and under what circumstances consent to health care is required. Nor is it an informed consent statute. As outlined in the Prefatory Note, this statute is basically a procedural one and matters of state substantive law are unchanged.

MODEL HEALTH-CARE CONSENT ACT § 11 comment, 9 U.L.A. at 472.
\textsuperscript{162} 579 N.E.2d 32.
\textsuperscript{163} IND. CODE ANN. § 30-5-2-4.
"Conservative groups . . . blocked passage of the bill for years" because they felt it "condoned suicide and euthanasia." 164 Before and after its passage, newspaper articles noted that the Act did not apply to nutrition and hydration. 165 After the Act's passage, one of its sponsors "asserted that the living will [was] not intended to justify denial of food, liquid or pain relievers." 166 Then, when the Indiana legislature faced an opportunity to delete the "appropriate nutrition and hydration" language, it rejected the opportunity. 167

Despite the fact that the legislature rejected the suggested revisions of the Living Wills Act, examination of the statutory language reveals that such a change is unnecessary. Although many legislators may not have questioned the inclusion of the word "appropriate," statutory construction rules support the consideration of all included words under the premise that each word must have been included for a reason. 168 In this case, attributing meaning to the word "appropriate" is consistent with medical consensus on the withholding or withdrawal of artificial nutrition and hydration, as well as with policies of self-determination and autonomy in health care decision making. 169

Two possible interpretations of the word "appropriate" exist. One possible, although not plausible, approach assumes that all nutrition and hydration are appropriate and thus not subject to removal under the Living Wills Act. However, this interpretation would be tantamount to saying that the word "appropriate" has no real meaning. The legislature could have deleted the word, and the same meaning would remain.

165. See, e.g., Senate Passes 'Living Will' Measure, Indianapolis Star, Mar. 28, 1985, at 17, col. 1.
166. Headden, supra note 164 (offering state senator William Vobach's conclusion). The fact that certain legislators attribute a particular meaning to language in the statute is not conclusory, for each legislator could offer different conclusions. Therefore, it is difficult to determine the intent of the legislature as a body.
167. Ind. H.B. 1131, 107th Gen. Ass., 1st Reg. Sess. This bill would have removed the "appropriate nutrition and hydration" language from Indiana Code § 16-8-11-4(b). It also would have added language to Indiana Code § 16-8-11-12 allowing a person to explicitly request that "artificially supplied nutrition and hydration" be withheld. The bill passed in the Senate, but the conference committee report was defeated in the House.
168. See, e.g., R. Dickerson, THE INTERPRETATION AND APPLICATION OF STATUTES 38-39, 198, 200-01, 205, 213, 230 (1975). Professor Dickerson noted: "[T]he only basis for applying a statute more restrictively than what a literal reading of the statutory language allows is through inferences of fact, based on a reading of the statutory language in light of its proper context." Id. at 200. See also In re Lawrance, 579 N.E.2d 32, 38-40 (Ind. 1991); F. McCaffrey, STATUTORY CONSTRUCTION 3-7 (1953). "In general, the doctrine of literalness demands that plain, unambiguous statutory language, expressing a single, sensible meaning, be interpreted to mean exactly what it says." Id. at 7. But see R. Dickerson, supra, at 227-36, 233 (1975) (where the author supports a "plain meaning 'presumption'" rather than a "plain meaning 'rule'").
169. See supra notes 50-59, 73-75 and accompanying text.
A second option reads the inclusion of the word “appropriate” as indicating that providing artificial nutrition and hydration may sometimes be inappropriate. The determination of the appropriateness would necessarily be the responsibility of health care providers in particular cases. This option recognizes the symbolic meaning of food and water in the traditional context, because oral nutrition and hydration would always be appropriate; only the provision of artificial nutrition and hydration would be treated as a medical procedure that may be withheld or withdrawn. This approach is consistent with the views of much of the medical community and considers the concerns of those who oppose the removal of nutrition and hydration because of their symbolic nature.

Legislators may not have intended any nutrition and hydration to be considered inappropriate and subject to removal. However, there is no way to verify this interpretation. Statutory interpretation encourages consideration of all words unless valid reasons exist for not doing so. Given

170. One court even reached this conclusion without the presence of the word “appropriate.” In McConnell v. Beverly Enterprises-Connecticut, Inc., 209 Conn. 692, 553 A.2d 596 (1989), the court construed the Connecticut Removal of Life Support System Act to authorize the removal of gastrostomy tubes, even though nutrition and hydration were excluded from the list of “life support systems” that could be withdrawn.

171. One could conclude that the word “appropriate” invites involvement of the courts. However, health care providers should be able to make these decisions. Safeguards that have been built into the Living Wills Act ensure that the decisions are properly made. The statute grants health care providers immunity from civil and criminal liability “for failure to provide medical treatment to a patient who has refused the treatment in accordance with this section.” Ind. Code § 16-8-11-10(c) (1988). “In accordance with this section” indicates that the patient is “qualified”; that is, that the patient has a “terminal condition . . . from which, to a reasonable degree of medical certainty . . . there can be no recovery . . . and death will occur from the terminal condition within . . . a short period of time without the provision of life-prolonging procedures.” Ind. Code § 16-8-11-9 (1988). The declaration must also be validly executed under the Act. Ind. Code § 16-8-11-11 (1990 Supp.).

The legislature obviously expects physicians to comply with medical standards in determining whether the “terminal condition” requirement has been met. Likewise, a determination of whether artificial nutrition and hydration are inappropriate, and thus a “life-prolonging procedure,” should be made by health care providers. If the requirements of the statutes are met, immunity from liability would follow.

These safeguards also appear in the Health Care Consent Law. There, procedures of appointments must be met, and if sufficient evidence of the patient’s wishes is unavailable, the best interests of the patient are considered, looking to appropriate medical standards. Ind. Code Ann. § 16-8-12-4 and § 16-8-12-6(h) (Burns 1990). See Lawrance, 579 N.E.2d at 42-43 (discussing controls on the decision-making process).

172. The fact that the statute does not distinguish between “artificial” and oral feedings supports this interpretation of the word “appropriate.” The Living Wills Act only speaks of “appropriate nutrition and hydration,” not “appropriate artificial nutrition and hydration.” Ind. Code § 16-8-11-4 (1988).

173. See supra notes 65-70 and accompanying text.

174. See supra note 166.

175. See supra note 168. The Indiana Supreme Court stated in Lawrance, 579 N.E.2d at 38: “We examine a statute as a whole, giving common and ordinary meaning to the words used.” Id. (citation omitted).
medical and judicial consensus, as well as policy reasons already discussed, the term “appropriate” should be read to allow health care providers flexibility. While not all physicians are comfortable with the removal of nutrition and hydration, the statute addresses this potential problem, because living will declarations are not binding upon physicians.176

B. The Health Care Consent Law: If Artificial Nutrition and Hydration Cannot Be Removed Under the Living Will Act, May a Health Care Representative Nevertheless Direct Their Removal?

The same representatives who sponsored the Indiana Living Wills and Life-Prolonging Procedures Act in 1985 presented the Indiana Health Care Consent Law177 that went into effect in 1987. However, unlike the Living Wills Act, the passage of the Consent Law was not controversial.178

The Health Care Consent Law addresses health care decision making for incompetent patients from a different perspective than the Living Wills Act. The Consent Law provides for other individuals to make decisions for an incompetent patient.179 A competent patient may appoint a “health care representative” and may include specific instructions for that representative to follow.180 If no representative was appointed to make the decision (either by the individual herself or by the courts), the Consent Law allows the health care provider to turn to family members with no order of preference identified.181 Unlike the Living Wills Act, the Consent Law does not require that the patient be terminally ill for the Consent Law to apply.182

The Consent Law, of course, deals with “health care.” It defines “health care” as “any care, treatment, service, or procedure to maintain, diagnose, or treat an individual’s physical or mental condition.”183 While one approach to the Consent Law concludes that it was never intended to deal with the removal of health care, especially care as controversial as artificial nutrition

176. Ind. Code § 16-8-11-11(f).
177. Ind. Code Ann. §§ 16-8-12-1 to -13 (Burns 1990 & 1991 Supp.).
178. A search of and by The Indianapolis Star and The Indianapolis News concerning the bill at the time it would have been discussed and was passed uncovered no articles.
179. The Consent Law is not entirely clear about which approach a surrogate decision maker should take to make decisions. On one hand, the statute states decisions should be consistent with instructions left by the incompetent patient. Ind. Code Ann. § 16-8-12-3(b). On the other hand, the statute explicitly states that decisions must be made in the best interests of the patient. Ind. Code Ann. § 16-8-12-6(h).
180. Ind. Code Ann. § 16-8-12-6(d).
182. Ind. Code Ann. § 16-8-12-3(a).
183. Ind. Code Ann. § 16-8-12-1(2).
and hydration, this conclusion is not supported by the *In re Lawrance* decision or the new Power of Attorney Act that supplements the Consent Law. However, reading the Health Care Consent Law as allowing the removal of nutrition and hydration conflicts with the Living Wills Act provisions. If nutrition and hydration may never be removed under the Living Wills Act, they could nevertheless be removed under the Health Care Consent Law.

The apparent policy of the Health Care Consent Law allows health care decision making that complies with an incompetent patient's wishes when those wishes are known. The Consent Law supports surrogates standing in the shoes of patients to make necessary health care decisions, even when the decisions involve artificial nutrition and hydration. The explicit language

---

184. See Thompson, *supra* note 160, at 182 ("The [Health Care Consent Law] 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.").

Support for the conclusion that the Consent Law was not intended to deal with the withdrawal of artificial nutrition and hydration and other life support was found within the statute itself: "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, withhold, or withdraw medical care necessary to prolong or sustain life." *Ind. Code Ann.* § 16-8-12-11(a). If the law did not affect "an individual's authorization to make a . . . decision for the individual," this could have simply meant that the removal of artificial nutrition and hydration, if not allowed under the Living Wills Act, will not be allowed under the Indiana Health Care Consent Law. One commentator explains:

> [T]he 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 a 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 prior to becoming incapacitated. 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. Given the legislative intent of these two Acts, the question arises whether an individual authorized to exercise consent under the Health Care Consent Act may consent to the withdrawal or withholding of life-supporting measures on behalf of a terminally ill patient.

Thompson, *supra* note 160, at 199 (citations omitted). However, even assuming the Living Wills Act never includes artificial nutrition and hydration as a "life-prolonging procedure," common law and constitutional principles remain a part of "Indiana law." As noted earlier, Indiana courts support the removal of artificial nutrition and hydration even without an appointed surrogate decisionmaker or a living will. See discussion *supra* notes 124-46 and accompanying text. Likewise, the fact that the chapter does not affect an individual's ability "to provide, withdraw, or withhold medical care necessary to prolong or sustain life" does not indicate that the chapter prohibits such removal by a surrogate; it only says that prior "Indiana law" stands. However, since one purpose of the Health Care Consent Law is to offer health care providers freedom from criminal and civil liability if they follow the terms of the statute, *Ind. Code* § 16-8-12-9, this freedom from liability may not occur if the provider would rely on her understanding of common law principles alone.

185. See Thompson, *supra* note 160, at 199 ("Indiana's Living Wills and Life-Prolonging Procedures Act, and now the Health Care Consent Act, are manifestations of the increasingly strong affirmation that an individual should have substantial control over his medical care.") (citations omitted).
of the power of attorney provisions incorporated into the Consent Law supports this conclusion.

C. Interaction of the Living Will and Life-Prolonging Procedures Act and the Health Care Consent Law

A number of possible interpretations of the Indiana Living Wills and Life-Prolonging Procedures Declaration Act and the Health Care Consent Law emerge. The best interpretation of the Living Wills Act is that artificial nutrition and hydration may be inappropriate; if they are inappropriate, their provision may be considered a "life-prolonging procedure" that may be withheld or withdrawn under the Act. Since the Consent Law includes artificial means of providing nutrition and hydration in its newly incorporated definition of "health care," any question of removal of artificial nutrition and hydration by a health care representative should be resolved by the statute.186

Avoiding the conclusions I have suggested yields inconsistent and illogical interpretations of these statutes. Imagine, for instance, that an individual has executed a living wills declaration expressing a desire not to receive inappropriate nutrition and hydration.187 If artificial nutrition and hydration never represent "life-prolonging procedures" under the Living Wills Act, then the support may not be removed under the Act. However, common law principles may allow such a declaration as evidence of the patient's wishes so that the nutrition and hydration may be removed anyway. Likewise, if the Health Care Consent Law is not related to the Indiana Living Wills Act, in some situations a surrogate may be able to authorize what the individual herself could not.

186. The question could be raised whether artificial nutrition and hydration provided by means not listed in the statute may be removed. However, this overly technical reading of the Power of Attorney Act should be avoided. The policies behind the Consent Law support a reading consistent with its underlying policies.

187. For example, one commentator has noted that an individual's living will actually contains this language:

Without affecting or limiting the generality of the foregoing, I specifically do not wish to have administered to me in the event of terminal condition treatments such as surgeries, dialysis, chemotherapies, radiations, pacemakers or blood transfusions, and I further do not want electrical or mechanical resuscitation of my heart when it has stopped beating, nasogastric tube feedings when I am paralyzed and unable to swallow and mechanical respiration when my brain can no longer sustain my own breathing.

Nocon, Indiana's Living Will After Cruzan, 83 INDIANAPOLIS MED. 832, 833 (1990). The interpretation of the Living Wills Act that I have suggested would give meaning to the above living will's reference to nasogastric tube feedings. However, use of language that strays from the form suggested in the statute would arguably not be "substantially in the form set forth" in the Act. See IND. CODE § 16-8-11-12 (1988). While I include this warning, this question is beyond the scope of this Note.
The only plausible interpretation of the statutes supports the ability to remove nutrition and hydration under both statutes or the inability to do so under both statutes. A tradition of patient autonomy in case law coupled with medical realities only support the conclusion that nutrition and hydration which are not medically appropriate may be subject to removal under either statute.

**CONCLUSION**

The word “appropriate” in the Indiana Living Wills and Life-Prolonging Procedures Act should be read to permit the removal of artificial nutrition and hydration when it serves as a “life-prolonging procedure” that prolongs the dying process. This conclusion not only recognizes the plain meaning of the statute itself, but it also recognizes judicial and medical support for such a conclusion.

Since immunity from liability serves as a foundation for both statutes, and since some interpretation questions exist, perhaps the legislature should delete the exclusion of appropriate nutrition and hydration from the Act’s definition of “life-prolonging procedure.” Nutrition and hydration, at least that which is artificially provided, would then clearly represent medical treatments. However, an amendment of the Living Wills Act would not be necessary if the word “appropriate” is interpreted as suggested here.

Health care representatives find the authority under the Health Care Consent Law to remove artificial nutrition and hydration when the patient has expressed this desire or when the best interests of the patient require it. When so directed by a surrogate decision maker determined to be capable of making decisions for the patient, health care providers receive the protection of the Health Care Consent Law even when the care in question is artificial nutrition and hydration. The Living Wills Act and the Consent Law should be viewed consistently with an eye toward allowing health care providers flexibility when dealing with medical alternatives.

188. See supra notes 89-123 and accompanying text.
189. See supra notes 37-49 and accompanying text.