The Terri Schiavo Debacle: What Have We Learned?

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The tale of Terri Schiavo began one night in 1990, with an unwitnessed cardiac arrest. Terri’s husband Michael reportedly heard a noise and ran into the hallway to find his wife prone on the floor, unresponsive. Terri’s electrocardiogram showed no electrical activity. She had suffered severe brain asphyxia (anoxic/hypoxic brain injury). The press has widely labeled this condition either “persistent vegetative state” or, more ominously, “permanent vegetative state.”

“Persistent vegetative state” and “permanent vegetative state” both require that the person in question be unable to experience the environment or respond to stimuli in any fashion. Three neurologists have testified that these criteria are true of Terri; however, her parents have disseminated widely video clips apparently demonstrating their daughter’s responsiveness to the environment and external stimuli. Two doctors have also stated that Terri is not in persistent vegetative state.

Years of deliberation in the court system eventually resulted in an October 2003 order to remove Terri’s feeding tube. Less than a week later, Governor Jeb Bush, acting under authority of an emergency Florida congressional edict, ordered that Terri’s feeding tube be reinserted. Regardless of what eventually happens, Terri Schiavo will join the ranks of Karen Ann Quinlan and Nancy Cruzan, whose cases are still being debated throughout the world today. We will likely never know the truth regarding Terri’s expressed treatment wishes.

What have we learned about life and ethics from this saga? On what issues will discussions focus? Likely these will include advance directives, the “right to die,” futility arguments, “quality of life,” and civility in civic discourse.

Advance Directives

Advance directives include living wills, health care power of attorney documents, and values statements. One might think that if a person’s wishes were spelled out in black and white, decisions regarding his or her health care would be relatively straightforward. Unfortunately, this is often not the case. What do phrases such as “if there is no hope of recovery,” “to alleviate further suffering,” or “extraordinary measures” actually mean? Each of these phrases can convey a variety of things, yet these are the kinds of terms often employed in advance directives.

In most states, a living will dictates the interventions that a person would not wish to have performed in the event of imminent death. Unfortunately, a person’s experience may alter his or her perceptions of the outcomes of such interventions. For example, “intubation and ventilation” may for many conjure up the thought of months on a ventilator, when it might in
actuality involve only two days on a respirator followed by a full recovery. Similarly, though many people think of a “feeding tube” as a painful nasal tube, “artificial nutrition and hydration” would include the administration of any intravenous fluids or parenteral nutrition, even if employed briefly.

In most states, the best tool to allow a person to make certain that his or her health care wishes are respected is probably the health care power of attorney document. This document may be used alone or in conjunction with written guidelines or values statements that a person’s appointed decision-maker (power of attorney) is authorized to interpret and apply. Unfortunately, many people sign such documents but fail to discuss their preferences with the person whom they have chosen to serve as their power of attorney should they become incompetent.

One problem with advance directives in general is the fact that a person’s wishes might change between the time a document is initially executed and the time that it is needed. This underscores the need for people to review their advance directives frequently so that their desires may be upheld.

Right to Die?
Where does the phrase “right to die” fit into discussions about the Schiavo case? This concept becomes relevant if Terri ever expressed a desire to be allowed to die if faced with her current circumstances. Did she ever express such a desire? The Schindler family adamantly denies that she did, while Michael Schiavo and his siblings claim the contrary (but provide no evidence to that effect).

If Terri had clearly stated her wishes regarding life-sustaining treatment, we would be compelled to respect them. Speaking out on Terri’s behalf, some vocal “life” advocates are claiming that society never has the right to withdraw a person’s feeding tube. However, since there is no moral or legal distinction between withholding and withdrawing medical interventions, and since we as humans maintain the right and responsibility to decide how our bodies are treated, we are compelled to respect patients’ requests to forgo care if they have indeed been clearly stated.

Futility
Futility is a complicated topic. While its basic definition of “no longer serving a useful function” seems straightforward, futility is not always easy to determine. For example, what type of “useful function” is in view here? Must an intervention be useful in restoring a patient to his or her previous level of health? Useful in restoring him or her to a modicum of social interaction? Useful in keeping him or her alive for another day?

The two concepts of usefulness—either progressing toward a significant degree of regaining lost function, or keeping a patient alive for another day—are quite different. Some in the “life” camp would in many situations see great usefulness in continuing intervention focused solely on sustaining biological life, whereas some in the “choice” camp would regard such intervention as futile. In their opinion, actions are futile unless they will restore a patient to useful functioning.

Quality of Life
Some extreme “life” proponents seem to believe that quality of life is so unimportant that it has no place in end-of-life decision-making. On the other hand, extreme “choice” proponents seem, at times, to regard this consideration as paramount in such contexts.

Nowhere in scripture does it say that when a person is in persistent vegetative state, multiple medical interventions must be undertaken—at any cost to the patient and society—in order to preserve life. Our laws also support the right to decline treatment.

Prior to the invention of plastic tubing, Terri would have died within weeks of her injury. C. Ben Mitchell, Ph.D., Senior Fellow at The Center for Bioethics and Human Dignity, states that plastic tubing was the single biggest confounding variable in twentieth-century bioethics. Is administration of a feeding tube a biblical mandate, equivalent to feeding those who are hungry (Matthew 25: 34-45)? Or is it, as numerous medical professional societies and the courts have ruled, an invasive medical procedure, which people may choose to forgo based on quality of life considerations?

Godly people may well end up on both sides of this question. As David Stevens, M.D., Executive Director of the Christian Medical Association, has pointed out, even the CMA constituency is split on whether it is ethically mandatory to maintain patients in persistent vegetative state indefinitely. So, given such disagreement, how should we disagree?

Conclusion
Terri Schiavo’s tragic story raises a number of difficult issues. As responsible citizens, we need to grapple with these—purposefully entering the public debate—while maintaining a sense of humility and fair play in our discussions. We also need to carefully consider our own health care wishes and, while we are still able, convey them in a clear manner.

Editor’s Note: CBHD has produced an advance directive kit designed to equip people to formulate and document their desires regarding end-of-life care. To order this new resource, please see p. 7 of this newsletter.