

Terri schiavo

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Nurs 2500: Ethical, Legal and Moral aspects of Nursing School of Advanced Nursing Education The University of The West Indies Melissa Balbosa Craigwell 811005170 Biography of Terri Schiavo On the 25th February 1990, 26-year-old Terri Schiavo suffered severe brain damage when her heart stopped for five minutes. In June of 1990, Michael Schiavo, Terri's husband, was appointed her plenary guardian by the courts. In September of 1993, Michael Schiavo authorized the nursing home she resides in to write a DNR (Do Not Resuscitate) order for Terri.

Schiavo spent the following years in rehabilitation centers and nursing homes but never regained higher brain function. In 1998 her husband, Michael Schiavo, filed a legal petition to have Schiavo's feeding tube removed, saying that his wife had told him before her medical crisis that she would not want to be artificially kept alive in such a situation. Terri Schiavo's parents, Bob and Mary Schindler, fought this request. Florida judge George W. Greer ruled in 2000 that Schiavo was "beyond all doubt" in a persistent vegetative state and that her husband could discontinue life support.

But as legal appeals in the case continued, the case became widely known as some religious groups and pro-life activists began to insist that Schiavo should be kept alive. Schiavo's feeding tube was removed in 2003, but reinserted six days later when the Florida legislature passed "Terri's Law," which allowed the state's governor to issue a stay in such cases. The law was later ruled invalid by the courts. At this time, there may also have appeared to be a conflict of interest, as Michael had two children with a long-term girlfriend.

In March of 2005 Schiavo's feeding tube was again removed, and the case became a greater public sensation when the U. S. Congress was called into special emergency session to pass a bill allowing federal courts to review the case, with President George W. Bush flying from Texas to Washington especially to sign the bill into law. However, federal judges and the U. S. Supreme Court refused to intervene. After two weeks without food and water, Schiavo died of dehydration on the 31st March 2005 at the age of 41.

Some of the ethical issues involved in this case include; autonomy, beneficence and non-maleficence, justice, religious views - Roman Catholic - sanctity of life, no advance directives, Terri's pre incapacitation verbal comments, and conflict of interest (familial, financial and institutional). The patient had severe brain damage. This followed a history of a sudden collapse secondary to cardiac arrest which resulted in prolonged cerebral hypoxia. She was diagnosed as being in a persistent vegetative state. Prognosis for patients in this state is poor. This condition is deemed to be chronic and irreversible.

The goal of treatment is to alleviate pain and suffering. The probability of success cannot truly be determined as the patient is unable to communicate. In this case rehabilitative efforts were found to be unsuccessful, and a court order was issued for life support to be ended. The patient benefits from medical care through treatment that alleviates any pain or distress. Nursing care also seeks to alleviate pain and distress through palliative care which seeks to provide comfort and maintain dignity. Harm is avoided when there are no conscious efforts to hasten or prolong death.

Terri Schiavo was not mentally capable and, therefore, not legally competent. The evidence of her incapacity lay in her inability to

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communicate. Buchanan 2004, stated that legal competence is specific to the task at hand. It requires the mental capacities to reason and deliberate, hold appropriate values and goals, appreciate one's circumstances, understand information one is given and communicate a choice. If the patient were found to be competent, then according to Michael Schiavo, she would be asking for treatment to be withheld and ongoing treatment to be withdrawn.

A patient's ability to self-govern is grounded in cognition (Fine, 2005). So, assuming she had the mental capacity to make her own decisions, her autonomy would have been respected and her decision upheld by the legal system. As a part of informed consent, all information would have been given to the patient concerning benefits and risks specific to her circumstances. She would have voluntarily indicated her understanding of treatment options available and given her consent in a written or oral form or possibly by some type of implied behaviour.

In her incapacitated state, the appropriate surrogate should, by moral and ethical standards be her husband Michael Schiavo and indeed, he was her court appointed guardian. Butts and Rich (2008) defines a surrogate as a court appointed individual who has the authority to make decisions on behalf of the patient. The question as to whether Mr. Schiavo used appropriate standards in his decision making can be measured against the principles for proxy decisions with incompetent patients as set out by Olick (2001).

These principles in relation to Terri Schiavo say that competent patients have a right to refuse life sustaining treatment, and he testified in court that prior to her collapse she verbalized that she did not wish to live like that, to

be a burden to anyone. Incompetent patients have the same rights they are, however, exercised differently. No right is absolute, instances in which a patient's right to refuse life support is outweighed by societal interests is rare, this case was one of those rare instances.

Withholding and withdrawing treatments from a terminally ill or permanently unconscious patient, does not constitute killing or assisted suicide. Terri was not diagnosed to be either terminally ill or permanently unconscious. A subjective standard of implementing the patient's wishes should have been used, and it was. It is recorded that the patient while competent clearly made her wishes known through informal conversations with several individuals, including her husband. There were no advance directives to rely on for guidance in this case.

Local processes of review in the clinical setting in order to facilitate the resolution of disagreements were denied by Mr. Schiavo, therefore, recourse to the courts which should have been rare were frequent. This analysis indicates that appropriate standards for decision making were utilized. Whether they were adequately utilized can be debated. Advance directives, as discussed by Butts and Rich (2008), include the use of formal, written legal documents, which may take one of three forms; a living will, a medical care directive or a durable power of attorney.

None of these, however, were used to express the patient's preferences. Terri had been medically assessed to be in a persistent vegetative state, with no higher brain function. In this state, it was judged that she would have been unable to cooperate with medical treatment. To say that she may have been unwilling would be denying her medical diagnosis, suggesting that she

did have the higher brain power necessary to choose between quality and quantity of life. In summary, I do not believe that the patient's right to choose was being respected to the extent possible in ethics and in law.

This is reflected in the absence of compliance with several of the principles for proxy decisions. These would be; the attempt to enable her to express her wishes, respecting society's interest for the continuation of life support, facilitating patient review to determine capacity and competence and finally not withholding and not withdrawing treatment from a patient who was not terminally ill or permanently unconscious. The New England Journal of Medicine (1994) discusses the prospect of return to a normal life with treatment. 'Therapy aimed at reversing the persistent vegetative state has not been successful.

There have been occasional reports of a benefit from dopamine agonists or dextroamphetamine, but the benefit has been modest at best, direct electrical stimulation of the mesencephalic reticular formation, nonspecific thalamic nuclei, or dorsal columns has been attempted experimentally in patients in a vegetative state, with claims of recovered consciousness in a few instances. The quality of the recovered state was not described in detail, however, and these approaches remain experimental. Overall, there is no published evidence that coma sensory stimulation improves the clinical outcome in patients in a persistent vegetative state. It continues to note that 'If the decision is to treat the patient aggressively, diligent medical treatment and nursing care are required to prevent and treat the complications that are likely or inevitable in states of severe brain damage. The survival of patients in a persistent vegetative state is, to some degree,

related to the quality and intensity of the medical treatment and nursing care that they receive. Preventive care is foremost. Daily exercises in a range of movements slow the formation of limb contractures, which otherwise become particularly severe in patients in a persistent vegetative state.

Daily skin care and frequent repositioning of the patient prevent decubitus ulcers. A tracheostomy may be required to maintain airway patency and prevent aspiration pneumonia. Bladder and bowel care is desirable for hygienic reasons. Since pulmonary and urinary tract infections are common, appropriate monitoring and, if necessary, treatment with antibiotics are required. Placement of nasogastric, gastrostomy, or jejunostomy feeding tubes is usually necessary to maintain adequate nutrition and hydration. ' The outcome probability at 12 months was determined in patients who remained in a vegetative state at 3 months and at 6 months. In addition, the probability of functional recovery was determined for two possible outcomes: good recovery or recovery with moderate disability, and recovery with severe disability. On the basis of these probabilities, a persistent vegetative state can be judged to be permanent 12 months after a traumatic injury in adults and children; recovery after this time is exceedingly rare and almost always involves a severe disability.

In adults and children with nontraumatic injuries, a persistent vegetative state can be considered to be permanent after three months; recovery does occur, but it is rare and at best associated with moderate or severe disability. ' NEJM (1994) ' Patients with a good recovery have the capacity to resume normal occupational and social activities, although there may be

minor physical or mental deficits or symptoms. Patients with moderate disability are independent and can resume almost all activities of daily living.

They are disabled to the extent that they can no longer participate in a variety of social and work activities. Patients with severe disability are no longer capable of engaging in most previous personal, social, and work activities. Such patients have limited communications skills and abnormal behavioral and emotional responses. They are partially or totally dependent on assistance from others in performing the activities of daily living. ' NEJM (1994) A bias does exist, according to Viswanathan et al. (2012), a reporting bias is the difference between reported and unreported findings.

This would have made a big difference to the results obtained from any form of continuous assessments at the hospice. Based on the very minimal treatment options chosen by Michael Schiavo, reflective in a refusal to allow physiotherapy, oral hygiene or antibiotic administration, we may deduce that a continuation of life, with contractures, infections and poor dental state would be undesirable. There was a plan to discontinue life support by having her feeding tube removed. There was also a DNR order in place. The reason for both of these actions was to prevent prolongation of her death.

The documentation suggests that there were plans for palliative care, as Butts and Rich (2008) points out that palliative care includes the choice to forego, withhold or to withdraw treatment, it also includes DNR orders. Palliative care does not hasten or prolong death, but provides relief from pain and suffering and maintains dignity in the dying experience. Michael Schiavo had a long-term girlfriend, with whom he had fathered two children, according to Funaro (2007). There may have existed a conflict of interest in <https://assignbuster.com/terri-schiavo/>

balancing the affairs of his newfamilywith the needs of his wife. He claimed that a part of him had moved, yet he still oved his wife so much that he was willing to fight to carry out her wishes. This conflict may have had an influence on his decisions. Provider issues that may have influenced treatment decisions, lie in the fact that the institution in which Terri was being cared for was one in which end-of-life management was carried out. The treatment provided by the hospice staff would only have recommended palliative care. Are there financial and economic factors? Yes. Fine (2005) tells us that ‘ Families may bankrupt themselves caring for patients in a persistent vegetative state, at which point Medicaid steps in.

Medical costs are the leading factor in bankruptcy. her parents objected to her being supported by government funds. The hospice caring for Terri Schiavo provided \$9. 5 million of charity care to patients in the past year. Another question of distributive justice relates to insurance. Can a society that cannot find enough resources to insure the 44 million persons (25% of whom are children) with no government or privatehealthinsurance really afford to maintain patients in a persistent vegetative state at a cost of \$40, 000 to \$100, 000 each per year? The lack of health insurance costs lives.

According to the Institute of Medicine, 18, 000 deaths per year are directly attributable to a lack of health insurance. ‘ Terri Schiavo had been a devout Roman Catholic, Lynn (2005) this religion upholds the sanctity of life. It was difficult for her parents to believe that she would not have wanted to hold on to life at all costs. They questioned whether Terri would have wanted to be starved to death. Their’s and by extension Terri’s prior existence was acultureof life. There are limits on confidentiality, the incompetent patient

still has a right to privacy and confidentiality. This right should be upheld by the legal guardian.

Treatment decisions are largely affected by the laws that govern options for patients to be able to choose to accept or refuse care, and for legal guardians to make decisions on their behalf when they are not able to. A great deal of clinical teaching and research is involved on an ongoing basis. It brings about new information and better ways of managing conditions. Yes there was a conflict of interest on the part of the institution. Lynn (2005) ' regulations generally prohibit a hospice from taking a patient who is not terminally ill and expected to live longer than six months to a year.

But Felos was chairman of the board of directors of the hospice at the time, according to the non-profit's annual reports, and was likely able to arrange for her admission. He subsequently stepped down from the post. ' George Felos was Michael Schiavo's attorney. The committee's specific findings related to this case are as follows; ' decisions near the end of life, whether to maintain a treatment that may not be beneficial or to withdraw or withhold a life-sustaining treatment, should be effectively handled in the majority of cases by the primary treatment team.

Ethics consultations are available and can be particularly valuable in cases of uncertainty or conflict. Palliative care consultations are available in cases of uncertainty or when needed to help manage complex symptoms, including physical, psychological, social, and spiritual suffering. Such suffering is often at the root of many an apparent conflict, and when the suffering is properly addressed, the conflict resolves.

When these efforts fail to resolve conflict over decisions near the end of life, the rule of law suggests that the conflict be resolved in a court and not in legislative deliberations for a single patient. At the end of all of the medical, legal, and ethical argument, it is most important to remember that no matter how certain any of us may be of our analysis, decisions near the end of life should never be easy. We must remind ourselves that true wisdom comes with the acknowledgment of uncertainty and admitting that we cannot know all there is to know.

This uncertainty is neither an excuse to engage in endless moral relativism or to engage in intellectual nihilism, refusing to search for the best possible solution or the least terrible outcome for a troubling moral problem. ' Fine (2005). In light of the above discussions, with heavy emphasis on the seven principles for proxy decisions with incompetent patients, the committee has decided against the removal of the feeding tube. The rationale for this decision, lies mainly in the fact that these principles were not upheld as best as they could have been.

As shown in the above discourse, a thorough attempt had not been made to closely follow these principles. As such, the committee recommends that the feeding tube not be removed. In conclusion, there is no traditional moral obligation to provide non-beneficial treatments based upon the classic goals of medicine, which are, according to Hippocrates, “ the complete removal of the distress of the sick, the alleviation of the more violent diseases, and the refusal to undertake to cure cases in which disease has already won mastery, knowing that everything is not possible to medicine”.

There is a traditional duty to relieve suffering, nicely restated by Sir William Osler 1849-1919: “ To cure sometimes, to relieve often, to comfort always. ”

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