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Reviving End-Of-Life Decision-Making:
How the Schiavo Case Demonstrates the Importance of Advance Directives
by Kerry R. Peck

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The fifteen year court battle over Terri Schiavo's fate put in the spotlight the controversial issues inherent in"right to die" cases. Like many Americans, young and old, Ms. Schiavo did not execute an advance directive (Power of Attorney or Living Will). When a heart attack struck, cutting off oxygen to her brain, she was left in a persistent vegetative state. This diagnosis was rendered reluctantly with arguable evidence to the contrary. Thus, the legal, scientific, moral, ethical and religious elements involved in a "right to die" case collided together in multiple courtrooms and the halls of Congress. Because Ms. Schiavo left no advance directive behind to effectuate her wishes, the ultimate decision was left to the court. The state and federal courts agreed with her husband/ guardian's opinion that Ms. Schiavo would not wish to prolong her life under the tragic circumstances that befell her.

Although the Schiavo case received substantial media attention, the issue in Schiavo is not new. In fact, the United States Supreme Court addressed a similar case in a 1990 decision. In Cruzan v. Director, Missouri Department of Health,[1] the Supreme Court declared that every individual has a constitutional right to control the scope of his or her medical treatment. The court held that in determining end-of-life decisions, health care professionals must have "clear and

convincing evidence" of a patient's desires. This threshold is easily met when a physician obtains the informed consent of a competent patient to provide or abstain from providing life-sustaining treatment. However, the issue becomes blurry when a patient's mental health is deteriorating, and becomes nearly impossible when the patient is comatose, incapacitated, or in a persistent vegetative state. In these situations, the physician is forced to rely on the input of family members or loved ones, and may be forced to seek guidance from a court.

Virtually every state, including Illinois, has enacted surrogate decision-making statutes to mitigate these harsh results. The Illinois Health Care Surrogate Act[2] is a mechanism to choose a surrogate to make health care decisions on behalf of an incapacitated individual when no power of attorney or other advance directive exists. The statute includes a prioritized list detailing who may serve as the individual's health care surrogate for certain medical decisions. The prioritized list includes, in order, an individual's: (1) legally appointed guardian of the person; (2) spouse; (3) adult son or daughter; (4) mother or father; (5) adult brother or sister; (6) adult grandchild; (7) close friend; or (8) legally appointed guardian of the estate.[3]

Once an individual becomes surrogate, he or she must make decisions on behalf of the patient using the "substituted judgment standard." This standard requires the surrogate to determine what the patient would have done or intended under the circumstances. If no evidence of the patient's wishes is present, then the surrogate must make a decision based on the patient's "best interest." This standard requires the surrogate to weigh the burdens and benefits of receiving life-sustaining treatment against the burdens and benefits of the treatment itself. Additionally, the surrogate can take into account any other relevant information including the views of the patient's family and friends.

The Illinois Health Care Surrogate Act is a default-based statute designed to protect the interests of individuals who lack decisional capacity and have not executed an advance directive.

Although the statute is beneficial under many circumstances, it does not eliminate the need for court intervention. As evidenced by the Schiavo case, family members may contest a surrogate's decision. Likewise, multiple surrogates in the same priority group (i.e., sisters or brothers) may disagree about the intentions of the incapacitated individual.

In an effort to prevent such situations, every state has enacted statutes outlining the legal requirements for executing advance directives. These documents recognize an individual's sacred right to control the scope of his or her medical treatment and constitute "clear and convincing evidence" of an individual's medical treatment decisions. Although the name of the documents vary from state to state, in Illinois, the documents include a living will[4] and a durable power of attorney for health care.[5]

A durable power of attorney for health care appoints an individual to act on a person's behalf to ensure that treatment is administered in accordance with the individual's desires. The individual who executes the document is called a "principal," and the person appointed is the "agent." The document itself is specifically tailored to reflect the principal's intentions. The Illinois legislature has created three choices for treatment. They are: (1) the use of life-sustaining treatment to prolong life without regard to the patient's condition, chance of recovery or the cost of the procedure; (2) the use of life-sustaining treatment to prolong life unless and/or until the patient is in an irreversible coma, in which case, life-sustaining treatment should be withheld or discontinued; and (3) the use of life-sustaining treatment to prolong life only if the principal's agent determines that the expected benefits of treatment outweigh the corresponding burdens. A durable power of attorney for health care may go into effect at any time, but is usually drafted to become effective at the time it is signed or when the principal lacks decisional capacity. When the document becomes effective, the agent has complete authority to direct the principal's medical care in accordance with her wishes. This authority includes accessing the principal's medical records and seeking court intervention on the

principal's behalf. The durable power of attorney for health care is the preferred document in Illinois.

A living will outlines an individual's desire to receive certain types of medical treatment. This document can dictate whether life saving treatments, such as artificial breathing, food, and water, should be provided or withheld under certain circumstances. In order to consider the contents of a living will, the individual must lack decisional capacity and must be terminally ill. Once these requirements are met, health care providers must follow the directions set forth in the document. No advocate is appointed by a living will, unlike the durable power of attorney for health care. If a health care provider is unable to comply with the living will, the provider must inform the hospital's administrative body and transfer the patient to another provider or health care facility.

If an individual executes both a living will and a power of attorney for health care, priority will be given to the power of attorney, provided the designated agent is willing and able to act on behalf of the principal. If an agent is unable to act, a validly executed living will is still effective. Additionally, even if an executed living will or durable health care power of attorney is invalid due to some technical defect, the document still provides evidence of the patient's wishes when the surrogate decision-making statute is invoked. Thus, both documents should be executed in order to ensure the broadest protection.

Both living wills and powers of attorney for health care have formal requirements: each document must be legally signed and witnessed. An estate planning attorney should be consulted to prepare these documents and ensure that an individual's wishes are properly effectuated in writing. After the documents are executed, the principal should provide copies to the agent, family members, and health care providers. These documents should not be placed in a safety deposit box since access will be time sensitive.

The Schiavo case focused attention upon the importance of planning for end of life decision-

making. However, the issues presented and the lessons learned are not new: the execution of a valid advance directive will allow the medical community and the court to honor an individual's intentions when she lacks decisional capacity. The advance directive will spare family and loved ones from engaging in a protracted, emotional legal battle. In Illinois, living wills and durable power of attorneys for health care are powerful documents that meet the requisite "clear and convincing" standard to demonstrate an incapacitated individual's wishes. Lacking a validly executed advance directive, individuals must rely on a state's surrogate decision-making statutes, like the Illinois Health Care Surrogate Act, to honor their intentions. While these default-based statutes are beneficial in some circumstances, they do not eliminate the need for court intervention and frequently end in a Schiavo-type battle. We can all learn from the Schiavo case. Plan ahead to avoid the courtroom struggle of medical, legal and religious-moral values and ethics to decide your fate.

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1. Cruzan v. Dir. Mo. Dep't Health, 497 U.S. 261, 110 S.Ct. 2841 (1990).

2. Health Care Surrogate Act, 755 ILL. COMP. STAT. ANN. 40/1-65 (2004).

3. Id. at 40/25.

4. Illinois Living Will Act, 755 ILL. COMP. STAT. ANN. 35/1-9 (2004).

5. Powers of Attorney for Health Care, 755 ILL. COMP. STAT. ANN. 45/4-1, et seq. (2004).