Medical Law and Ethics: Medicolegal Issues at End of Life

The conversation about the preservation of the life of a patient in the face of inelastic needs and finite resources is significant in small jurisdictions such as the Caribbean, and specifically Barbados. It is one that traverses several socio-political and ethico-legal issues that are emotionally charged in relation to end of life decision-making. It is also a conversation which engages the human rights of the patient and may conflict with the duty of the medical practitioner, who whores a duty of reasonable care to provide standard medical treatment and a duty to act reasonably in the patient's best interest in withholding or withdrawing medical care.

When discussing End of Life care, the arising question is what decision(s) can the patient, the medical practitioner and the family members make in relation to end of life issues that do not assail moral and/or ethical values, and without offending the law. In this conflictual situational, the objective of this discussion is whether the law of Barbados should be altered by statute to provide for Do Not Resuscitate ("DNR"), Assisted Suicide and so on to avert the violation of the constitutional rights of the patient and so avoid offending the law.

These questions will be approached from the perspective of potential services that a medical practitioner can offer a patient who has reached the point where his/her quality of life is so diminished that it is not worth living.

The medical practitioner may have formed the view that a patient's quality of life is so futile that based on the ethical principle of utility, it may not be worth prolonging, all things considered which may incline the medical practitioner to apply the DNR status. This approach may be ethically acceptable if the practice is based on economic utility in medicine. However, it may warrant a charge or murder or manslaughter.

The DNR stats may be applicable in two situations:

1. Where the medical practitioner makes the decision that the patient has no mental capacity and his/her quality of life is not in good standing; and
2. Based on an expressed view of the patient with mental capacity.

The medical practitioner is not obliged to preserve the life of a person who has mental capacity, and who frequently and voluntarily states that he does not wish to be ventilated or resuscitated if certain events occurred. Providing that the evidence is available to support this position, the medical practitioner may place a DNR status on such a patient.

There are two hurdles the medical practitioner needs to overcome:

1. The principle that the doctor should "do no harm to his/her patients";
2. The sanctity of human life which is a State's compellable interest.

It does not follow inexorable that giving a patient a DNR status is necessarily doing harm; death may be better than the quality of life that the patient has remaining. However, this would lead to a moral argumentation. That apart, the medical practitioner may be ethically censored and/or face criminal sanctions. The sanctity of human life is a State's compellable interest, which the state must protect. Lord Keith of Kinkel in *Airdale NHS Trust v Bland [1993] AC 789* at page 859 said: "…the principle of the sanctity of life, which it is the concern of the State, and the judiciary as one of the arms of the state... is not an absolute one. It does not compel a medical practitioner on pain of criminal sanctions to treat a patient, who will die if he does not, contrary to the express wishes of the patient."

Do Not Resuscitate (DNR)

It is to be noted that there is no decision for the medical practitioner to take the patient's best interest into consideration once the patient has mental capacity. The medical practitioner is obliged to respect the will of the patient as demonstrated in this *Ms. B v An NHS Hospital Trust [2002] All ER 362*. Nevertheless, where the patient is not of a sound mind, as certified by two Psychiatrists, then the medical practitioner has a duty to act in the best interest of the patient whether the medical practitioner will ventilate or resuscitate the patient. I would hasten to add that the medical

practitioner cannot act unilaterally and place a DNR without the consent of the family or other significant persons to the patient: *Ms. B v An NHS Hospital Trust [2002] All ER 362.*

Living Wills/Advance Directives

In this instrument a person (patient) can decide what should happen where he/she clearly expressed the wish for treatment to be withdrawn in the event of her/him suffering a life-threatening condition, permanent mental impairment or permanent unconsciousness, or some such catastrophic personal injury. Ethically, the medical practitioner must do what is in the best interest of the patent, having consulted with the next-of-kin, family members and/or other significant persons to the patient, supported by at least two psychiatrists. However, as there is no legislative framework for Living Wills to be acceptable in Barbados, the medical practitioner may face criminal sanctions under the Offences Against the Person Act CAP. 141 for murder or manslaughter. Nonetheless, the medical practitioner may escape criminal liability if she/he can show that she/he did not intend to cause the death of the patient but rather to ease his/her pain: *Airedale NHS Trust v Bland [1993] AC 789.*

Voluntary/Involuntary Euthanasia/Assisted Suicide

Euthanasia is mercy killing. It may be voluntary, that is, the patient brought about his own death and involuntary whereby the death of the patient is brought about by the medical practitioner. Euthanasia is illegal in Barbados whether voluntary or involuntary. The medical practitioner may face criminal sanctions. In a situation of assisted suicide, that is, where a medical practitioner facilitates the death of the patient, is illegal in Barbados under s.12 of the Offences Against the Person Act CAP. 141, and as such the medical practitioner may face criminal sanctions.

Finding a feasible defence for the medical practitioner for Assisted Suicide is difficult. The one thing that comes to mind is human compassion to ease the pain and suffering of the patient, but that 'flies in the face' of Euthanasia. But where the patient is competent and the medical practitioner agrees to assist, he/she may use the argument of the right to die. Notably, this argument has failed several times in the UK Courts: *The Queen on the Application of Pretty v The Director*

of Public Prosecution, et al [2001] UKHL 61. However, the argument succeeded in the Supreme Court of India in the case of *Aruna Ramchandra Shanbaugh v Union of India and Others, March 2011*. The ancient argument that one does not have the right to die was defeated. The Supreme Court of India had formed the view that just as there is a right to life, there must also exist its corollary, the right to die.

Palliative Care

Palliative care may be defined as an interdisciplinary medical caregiving approach, the objective of which is to optimize the quality of life and mitigate suffering among people with serious, complex, and often terminal illnesses. On the face of it, palliative care appears to be innocuous and therefore no criminal sanctions should be attached to it.

Legislative Intervention Required

Until there is a change in the traditional definition of death in the law of Barbados, that is, the cessation of the cardiovascular system instead of brain death, medical practitioners remain in peril of criminal sanctions. Such a change of definition, facilitated by proper guidance and monitoring would remove the conflict that arises in this medicolegal issue.