# **Legal Healthcare Issue**

A legal battle has come to the public attention involving Chard Charlie and the UK’s doctors involving the substitution of assisted suicide with experimental treatment. Although the law applies to the regulation of healthcare sector, a dilemma emerges in defining the responsibilities of a doctor or a physician in delivering medical care to patients and application of sound decisions in the medical setting. While the subjects of assisted dying and euthanasia still face great public criticism and legal ban in various nations, it is in the healthcare practitioners’ interest to evaluate the role of doctors in delivering care. The legal battle involved in the case of Charlie takes into account the inability of doctors to deliver medical assistance and intervention to patients without the involvement of control and regulation policies. Thus, this writing aims to address the Do-Not-Resuscitate Order, Physician Assisted Dying, and euthanasia in light of Charlie’s legal battle against the law banning health care practitioners from assisting terminally ill patients, patients in permanent vegetative state, patients with no likelihood of healing, and patients undergoing extreme chronic pain in committing suicide or seeking alternative medical attention. Various examples similar to Charlie’s case are addressed briefly to evaluate their similarity and the historical background of the matter. However, while the law plays a significant role in controlling the conduct of physicians, the availability of assisted dying services and alternatives showcase a dilemma in the healthcare delivery system and also questions the involvement of government controls in delivering health care justice.

The case of Charlie arose when the parents of the infant proceeded to court to be allowed the right to take their child for an experimental treatment provided the UK health care system does not favorably agree with the concept of death with dignity. In the case of Charlie, the infant suffers from incurable disease whose effects on the body are the inability to develop muscle and brain functionality (Bowcott, 2017). Since the parents of the infant were initially of the idea to stop the life-support system and allow Charlie to die with dignity, they have instead decided to opt for an experimental treatment in the US. In the UK, doctors and judges argue that Charlie should remain on life support until he dies naturally and at the same time, US’s experimental treatment is considered unethical and undignified (Douthat, 2017). With reference to the differences in the arguments of the US and UK doctors that the treatment can work and it is impractical respectively, a division in the delivery of medical care is observed within these two regions. The moral concerns and the legal situation not only showcase a lacking need for best practice standards in handling end of life situations. The roles of the doctors in the UK in aiming to sustain life without the hopes of recovery and the performance of an extreme medical intervention in the US highlight a sense a gap in health care justice delivery. The facts of the case beg the question of whether Charlie’s parents or the judges and doctors in the UK have the mandate to choose what it best for Charlie with reference to medical intervention and application of health care best practices. Additionally, the question of whether medical interventions becoming too extreme should allow for illness and death to occur naturally (Douthat, 2017).

The biggest challenge in the case of Charlie comes down to the healthcare management policies of determining when one decision is worse than another and justifying both with logical viewpoints. For instance, in the UK, doctors have ruled through evidence that Charlie cannot recover and the looming death of the infant should be decided on based on health care, judicial, and ethical considerations at hand. The first health care concern is the conflict between moral and legal actions relating to the challenge in decision-making. The doctors have evaluated the health condition of the infant and ruled out further medical intervention besides life support regardless of the definite death coming to the infant (Douthat, 2017). On the other hand, the parents know that not doing something would not prove trying the experimental treatment was a wrong decision. On the moral part, the judicial system observes that the UK does not have the medical capacity to carry out any medical intervention that would cure Charlie but at the same time it is skeptical of a procedure that has never been attempted before on an actual case. On the contrary, Charlie’s parents share the moral concern with the judicial system only that they consider failure to try is a direct denial of their rights to make decisions concerning the health of their child. The doctor in the US offers to treat the condition through an experimental intervention which is a move considered unethical to administer experimental medication to human subjects (human lab-rats).

In addressing the legal and moral dilemmas associated with the case, it is important for the health care system to recognize the role of doctors in delivering medical interventions. Trough evidence-based treatments and medical interventions, doctors, physicians, and nurses are required to rely on research and sector best practice. Research in health care is considered the backbone of medical advancement and informs practice of the best courses of action to take. Sector’s best practice on the other hand, involves the use of standard procedures in giving medical advice, attention, or follow up. However, the sector’s best practices are in jeopardy of being irrelevant and meaningless to practitioners with government interruptions. In the current case, Charlie’s parents are the only ones that can give consent to the medical institution to proceed with any recommended treatment. Given the parents are of sound minds and with no ill-intentions with the child’s life, the judicial system should work with the health care sector as a whole to not only evaluate the sense of each argument. The courts can decide that the parents’ decision may be dangerous and should therefore be stopped while the doctors on the other hand, have the mandate to consult with one another regarding the practicality of the proposed treatment (Bowcott, 2017). Thus, the current UK health care justice is indicative of problematic exercise of best practice and meriting of legal arguments. The fulfillment of a practitioner’s role is through the full exercise of informed decision-making with all risks considered and addressed readily with the other stakeholders. The conflict of agreement between the UK and US doctors shows lack of reliable evidence on the practicality of the procedure but the certainty of death does not make the argument of UK doctors any less debatable.

Various other cases on assisted death and the role of doctors and physicians show the moral and ethical factors relating to end of life care. Within the health care industry, doctors and physicians can prescribe a do-not-resuscitate order whereby a patient determined to be in a permanent vegetative state, incurable, or needing no further intervention is not mechanically resuscitated in case his/her heart stopped beating and the breathing ceases. Considering that resuscitation can extend the life of a patient after breathing stops, it also extends the suffering of the individual at hand. As applicable to the role of doctors in administering medical care, extending the life of a patient is a higher concern but also takes account of various moral perspectives. For instance, if a patient requests for a lethal dosage or a prescribed overdose to end his/her life, it is of more significance that the practitioner considers priority duty to preserve life. Applicable to the Charlie’s case is that doctors in the UK would rather let a child die naturally after a short time than neither relieving that child of the pain nor attempting a non-negligible but extreme medical intervention. If the do-not-resuscitate order is valid in medical settings, it is also considerable that in place of assisted suicide or euthanasia, a likely solution to extend the life of a patient should be considered a doctor’s responsibility in delivering medical care. Since the law and the stakeholders’ interests are likely to conflict every once in a while on matters such as these, it is recommended that alternatives other than doing nothing to end the kids suffering serve the doctors’ responsibilities better (Bowcott, 2017).

The responsibilities of a health care practitioner and a doctor in particular is to exercise his/her full knowledge in intervening, managing, and offering sound advice to patients and other practitioners when handling a relevant problem. In this case, I recommend that use of research and development in the health care system should be considered a move towards prosperity and sustainability in delivering quality care. Reflecting on the case of Charlie, there are no options other than the obvious to the parents according to UK doctors. If it solely depends on UK doctors in deciding the fate of the child, death with dignity would be out of the question due to legal constraints and the only option is to let illness and death take their course (Murphy, 2016). However, considering the health care system as a whole, best practice must be considered at all times considering that it is not the decision of the UK doctors to disregard the solutions of other medical practitioners outside the UK domain or liaise with the judicial system in preventing parents/guardians from exercising their right to give consent for alternative treatments (Bowcott, 2017). For patients are allowed to refuse medication, they should be allowed to use doctor recommendations to try other options. A doctor will be conducting a professional mistake to administer medical intervention that a patient or next of kin refuses to have administered. As a result, it is also a professional misconduct that UK doctors are refusing to let Charlie off their life-support system into the medical setting of US doctors (Murphy, 2016). The invalidity of UK doctors’ argument that Charlie should not be subjected to new technological intervention is amplified by the lack of a better solution. Whether or not the UK doctors have a valid argument in releasing Charlie to another doctor, failure to try changes nothing but trying could mean saving the lives of other future cases. If the intervention gives positive results despite it not having been tried before, it would communicate its applicability and the needed improvements (Bowcott, 2017). However, if it is not tried, the outcome would not be known and the administration of the intervention to human subjects would cease unless trials are performed on volunteers.

The impact of substituting assisted death with trial or experimental treatment is that it does not support the moral arguments on the matter. Without support for the moral considerations especially those surrounding the society and the responsibility of the healthcare sector, it is irrelevant consider health care an independent sector and able to administer medical interventions within best practice expectations (Murphy, 2016). One moral consideration to the health care fraternity is that it must sustain life as much as possible with reference to the situation at hand. In addition, to the society it is immoral for the healthcare to prescribe alternatives that do not support the philosophy of free will. Based on evidence-based practice, practitioners diagnose medical conditions and prescribe alternatives based on the sector’s technical abilities. Likewise, practitioners in the health care sector will advise users whether their conditions are treatable or not. However, with a division in the application of innovative solutions in the health care setting leads to confusion in the applicability of reliable intervention as well as likely solutions to problems without confirmed solutions (Murphy, 2016). As result, if Charlie’s end of suffering will take death, then the likely solution to use another alternative offers the sector an opportunity for growth and development. Doctor and physician scientists around the world can use the motivation from an allowed experimental treatment to do better in the future and also to prescribe likely solutions to conditions that have been historically been ruled incurable (Murphy, 2016).

The integration of new and old information on the manageability of medical conditions shows that extreme conditions that lead to ultimate death have mostly influenced patients to request for assisted suicides. However, with the emergence of innovative and trial treatments, more terminally ill patients will be able to take advantage of the health care research to improve their lives or to support the sectorial development of reliable alternatives. Use of terminally ill human subjects as genie pigs is ethically wrong but with informed consent and a likely positive outcome serves the interests of other patients and the public domain as a whole. It is therefore the role of UK health care administration to ensure that scientific innovations in medical interventions are evaluated in terms of their applicability to draw positive outcomes rather than one-sided concern with the failed attempts (Bowcott, 2017). Other medical interventions such as palliative care consider life sustenance and comfort essential inputs in healthcare while assisted death considers the unavailability of alternative solutions (Showalter, 2014). Since alternatives do not rule out risks, the extent of the risks and the expected outcome should be balanced to make a reliable decision. For the cases similar to Charlie’s, the final outcome of waiting for natural death is death and risks include continued suffering and further spending on life-support. On the one hand, the outcome of assisted death is death and risks include possible lawsuits by differing stakeholders while benefits include the end of suffering and disengagement with the financial burden. On the other hand, substituting assisted death with trial treatment has two expected outcomes one being the condition can be contained or not while risks include triggering of an earlier death while the second can be increasing suffering through the induction of side effects of the treatment (Carayon, 2016).

By carefully examining the roles of doctors in the care settings, it is professionally expected that the life of a patient depends on proper integration of knowledge, practice, and standards of health care. Chronic pain, vegetative states, permanent comma, and incurable diseases all increase the likelihood of meriting assisted suicide. However, through research and development, reliable alternative innovations are offered to the health care sector to improve patient outcomes and practitioners make use of these tools to extend the lives of patients. However, on the dilemma of whether available alternative is reliable or not raises a justice concern regarding whether a doctor can prescribe assisted suicide to end suffering, alternative treatment to ease the problem, or let illness and death take their courses (Murphy, 2016). From the above considerations, moral and ethical concerns are heavily associated with the decision to kill a patient with consent disregarding an alternative or declining to take action in a developing medical situation. Therefore, in the delivery of care, doctors and other medical practitioners responsible for the well-being of patients must be governed by a judicially recognized policy which takes human dignity as the integration of logic, available alternative, and overall outcome in sustaining one’s moral values and beliefs (Showalter, 2014). Informed consent and inclusive understanding of health care capacity should give doctors and other practitioners a sense of responsibility in delivering medical assistance whenever the need is eminent, alternatives are available, and possibility of achieving positive outcome is non-negligible.

## References

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