

Responding to Calls to Legalise Euthanasia and Physician-Assisted Suicide in Singapore

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Abstract

Proponents of physician-assisted suicide and euthanasia (PAS/E) assert that mentally competent terminally ill patients experiencing 'intractable' physical and/or existential suffering with no means of alleviating this suffering should be afforded the right to end their lives at a time and place of their choosing. A significant obstacle to legalising PAS/E has been the slippery slope argument that posits that gradual abuse of PAS/E is inevitable, leaving vulnerable patient groups of patients susceptible to its use. To distance this practice from the slippery slope, proponents of PAS/E proffer the concept of "Medical Aid-In-Dying" (MAID) that boasts of strict criteria for its use and forward evidence that its use in Oregon and the Netherlands has revealed no evidence of vulnerable patients being coerced into having PAS/E. This paper assesses the position and the assertions brought by proponents for the legalization of MAID in Singapore using an evidenced based socioculturally sensitive approach to contextualise these arguments. Socioculturally, prevailing Confucian-inspired family-centric practices hinders informed consent and creates coercive influences upon the decision-making process that will hinder effective consent for MAID whilst clinical evidence highlights inherent inaccuracies within determinations of prognosis and intractability that compromise legitimate application of MAID. This paper highlights the need for socioculturally sensitive, evidenced-based evaluation of all extrapolated data to consider the impact of prevailing mores and laws upon its application within the local scene. Singapore's culture, clinical practice and laws do not support use of MAID locally.

Keywords: Euthanasia, Medical Assistance In Dying (MAID), Palliative Care, Vulnerable Patient, Confucian

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I. Introduction

Callahan suggests that “no moral impulse seems more deeply embedded than the need to relieve human suffering.”¹ Drawn from the Greek words ‘eu’ (good) and ‘thanatos’ (death), euthanasia and latterly physician-assisted suicide (PAS/E) is often portrayed as the ‘right’ of an autonomous terminally ill patient suffering with symptoms that are not amenable to conventional treatment options.² Death is seen as acceptable when living is likely to mean continued suffering without hope of relief till death finally comes. Questions over the legal, ethical, sociocultural and clinical basis of PAS/E, and the implications upon the practice of medicine and palliative medicine, have seen the right to self-termination remain controversial and efforts to legalize PAS/E face a variety of barriers.

One of the most significant barriers to PAS/E has been the ‘slippery slope’ argument fuelled by lessons from Nazi Germany.³ Here creeping expansion of euthanasia for terminally ill patients, its insidious application on the disabled and vulnerable to its use to cull political opponents and exterminate ‘racially undesirable elements,’ such as homosexuals, Jews, Polish, Romani, Slavs and peoples of African descent, underpins modern concepts of the slippery slope argument within the context of PAS/E.⁴ Less overt than blatant erosions of guidelines and safeguards set out to prevent abuse of euthanasia are the subtle shifts in thinking that began with embracing the notion that there was such a thing as a “life not worthy to be lived,” to the gradual acceptance that the “feeble minded,” the “socially unproductive, the ideologically unwanted, the racially unwanted” could be murdered on the premise that they did not “deserve to live.”⁵ It is this denigration of the value of human life that

¹ Daniel Callahan, *The Troubled Dream of Life: In Search of a Peaceful Death* (Washington, D.C: Georgetown University Press, 1993).

² Lukas Radbrunch et al., “Euthanasia and physician-assisted suicide: A white paper from the European Association for Palliative Care,” *Palliative medicine* 30, no. 2 (2015): 104-16; “Compassion & Choices,” Accessed February 18, 2019, <https://www.compassionandchoices.org/>; McMurray, Richard J et al., “Decisions Near the End of Life,” *JAMA: The Journal of the American Medical Association* 267, no. 16 (1992): 2229-33; Wong, Yang-Sheng, and Lois M. Verbrugge. “Living Alone: Elderly Chinese Singaporeans,” *Journal of Cross-Cultural Gerontology* 24, no. 3 (2008): 209-24.

³ Smith, Stephen W, *End of Life Decisions in Medical Care: Principles and Policies for Regulating the Dying Process* (Cambridge: Cambridge University Press, 2012).

⁴ *Ibid.*

saw prisoners in concentration camps subjected to research without consent, and finally to genocide, and this underpins more modern concepts of the slippery slope arguments.⁶ The ‘slippery slope’ argument premises that similar creeping violations of the structure and control of PAS/E that precipitated its abuse in Nazi Germany would be repeated and lead to 1) manipulation or coercion of patients into requesting assistance in hastening death, 2) members of vulnerable groups being disproportionately affected, 3) patients with impaired judgement allowed to request for PAS/E, 4) extension of PAS/E to include involuntary euthanasia and 5) impairment in the quality of palliative care for all patients.⁷

II. A ‘new’ challenge to the slippery slope argument in Singapore

Though illegal in Singapore, efforts to legalise PAS/E continue as various parties jostle to influence public opinion. Aware of concerns about potential abuse of PAS/E prevailing concepts and practices of PAS/E have been revamped. Based on the modernized concept of PAS/E built on data from Battin et al⁸ that concluded that the rates of assisted dying did not increase amongst the ten most vulnerable groups of patients, which include the elderly, women, the uninsured, people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, and racial or ethnic minorities, following evaluation of annual reports from the Department of Human Services in Oregon. Four government commissioned nationwide studies and three independent studies following Oregon’s enactment of the Death with Dignity Act in 1997 and specialised studies in the Netherlands, Battin surmised that concerns about the slippery slope to abuse of

⁵ Michael Berenbaum, *The World Must Know: The History of the Holocaust as Told in the United States Holocaust Memorial Museum* (United States Holocaust Memorial Museum: John Hopkins University Press, 2015).

⁶ Berenbaum, *The World Must Know: The History of the Holocaust as Told in the United States Holocaust Memorial Museum*; "Victims of the Nazi Era: Nazi Racial Ideology," United States Holocaust Memorial Museum, accessed February 18, 2019, www.ushmm.org/wlc/en/article.php?ModuleId=10005143.

⁷ Sumytra Menon, “Euthanasia: A Matter of Life or Death?” *Singapore Medical Journal* 54, no. 3 (2013): 116-28.

⁸ Battin, M. P. et al., “Legal Physician-assisted Dying in Oregon and the Netherlands: Evidence concerning the Impact on Patients in ‘vulnerable’ Groups,” *Journal of Medical Ethics* 33, no. 10 (2007): 591-97.

PAS/E are unfounded and that PAS/E should be encouraged based on autonomy and rights.⁹

To further strengthen its position, strict prerequisites for the use of PAS/E have been implemented with the introduction of the term “Medical Aid-In-Dying (MAID).”¹⁰ Patients seeking “Medical Aid-In-Dying” must be deemed to be terminally ill with a prognosis of less than 6 months and must be determined to be suffering unbearable symptoms that are not amenable to standard treatments resulting in little prospect of improvement in their symptoms (intractable suffering). Valid employ of MAID also requires that the patient must be fully aware of his/her condition and prognosis, must be acting voluntarily and free of coercive influences and must maintain a consistent wish for this treatment when requesting for MAID.¹¹ Valid use of MAID also requires certification by a second independent physician that all the requirements for MAID have been met. This essentially means that there is no conceptual difference between MAID and PAS/E. However, this ‘safety first’ approach backed by clinical data has seen MAID advocated for in Singapore.

III. PAS/E in Singapore

Given that much of the current data is drawn from Dutch and American settings, a three-pronged approach is adopted to contextualize the evidence and consider the impact of local sociocultural, ethical, legal and practical factors when evaluating the validity of the data and viability of MAID in the Singapore setting.

1. Sociocultural Considerations

The ‘legitimacy’ of MAID¹² locally depends on its viability in the eyes of prevailing sociocultural considerations.

⁹ Ibid.

¹⁰ Ibid.

¹¹ Battin, 591-97.

¹² Ibid.

a. Family-centric practices

A pivotal sociocultural consideration affecting the feasibility of MAID is informed consent. Here locally interpreted concepts of Confucian-inspired family centric practice, create familial obligations, create responsibilities for patients and families to care for one another. Family members are endowed with three overarching duties.¹³ The Duty to Care requires family members to provide physical, existential, practical, social, and financial care. The Duty of Non-abandonment demands that this support continues till the death of their loved one. The Duty to Maintain Hope is derived from the belief that patients should be spared bad news that would drain their hopes and expedite their demise.¹⁴ Failure to meet any of these filial obligations risks a ‘loss of face’ or a loss of personal honour and dignity, a fate fearfully avoided locally.¹⁵

Patients are entrusted to advance the overall good of the family even at the expense of their own individual rights and interests, allow family members to care for them, and be exemplars for the younger generation in continuing to fight throughout their illness and never give up.¹⁶ Failure to do this would be a loss of face for patient and

¹³ Wong and Verbrugge, 209-24; Lalit Kumar Radha Krishna, “Could Meeting Familial, Psychosocial and Cultural Expectations under the Aegis of Palliative Care Result in a Slippery Slope to Hastening of Death?” *Palliative Medicine & Care: Open Access* 1, no. 1 (2014); Min Kai Chang et al., “The Influence of Evolving Confucian Beliefs in the Selection of Proxy Decision-Makers at the End of Life in Singapore,” *Asian Bioethics Review* 9, (2017): 117-28; Peggy Teo, “Health Care for Older Persons in Singapore,” *Journal of Aging & Social Policy* 16, no. 1 (2004): 43-67; Khan, Habibullah. *Social Policy in Singapore: A Confucian Model?* Washington, D.C.: World Bank Institute, 2001; Ho, Zheng Jie Marc, Lalit Kumar Radha Krishna, and Chung Pheng Alethea Yee, “Chinese Familial Tradition and Western Influence: A Case Study in Singapore on Decision Making at the End of Life,” *Journal of Pain and Symptom Management* 40, no. 6 (2010): 932-37; Ong Eng Koon, Lalit Kumar Radha Krishna, and Patricia Neo, “The sociocultural and ethical issues behind the decisions for artificial hydration in a young palliative patient with recurrent intestinal obstruction,” *Ethics and Medicine* 30, no. 1 (Spring 2015): 39-50.

¹⁴ Manderson, Lenore, Eddie C. Y. Kuo, and Aline K. Wong, “The Contemporary Family in Singapore: Structure and Change,” *The Journal of Asian Studies* 39, no. 4 (2006): 878; Walter H. Slote, and George A. De Vos, *Confucianism and the family* (SUNY Press, 1998); Thomas, Elwyn, “Filial Piety, Social Change and Singapore Youth,” *Journal of Moral Education* 19, no. 3 (1990): 192–205; K. Jane Ong et al., “Cultural Attitudes to cancer management in traditional Southeast Asian Patients,” *Australasian Radiology*, (2002).

¹⁵ Ho, Krishna and Yee, 932-37.

¹⁶ Chang et al., 117-28; Ho, Krishna and Yee, 932-37; Lalit Kumar Radha Krishna, Deborah S. Watkinson, and Ng Lee Beng, “Limits to Relational Autonomy-The Singaporean Experience,” *Nursing Ethics* 22, no. 3 (2014): 331-40; Lalit Kumar Radha Krishna, and Sumytra Menon, “Understanding the Practice of Collusion on End of Life Care in Singapore,” *JMED Research*, (2014): 1-8; Chong, Jia An et al., “Patient and Family Involvement in Decision Making for Management of Cancer Patients at a Centre in Singapore,”

family with the idea being that the patient was not appropriately cared for by the family or did not trust them.¹⁷

The implications of filial obligations upon MAID are stark when considering that at the heart of the Duty to Care and the Duty of Non-abandonment is the hope of returning the family member to their previous condition. Discussions about hastening death would be a clear breach of these obligations and be a compromise to the Duty to Maintain Hope.

There are other less overt implications of filial duties upon the consent process.¹⁸ To begin with, valid use of MAID demands that the patient is aware of the process and either requests or agrees to it. Here the Duty to Maintain Hope has telling implications by creating obligations to preserve hope and ‘protect’ patients from ‘bad news’ which encourages collusion, familial determination and the circumnavigation of direct patient involvement in end of life decision making.¹⁹ Highlighting the extent of compromise of informed consent, Phua et al²⁰ reported that little more than 15% of

BMJ Supportive & Palliative Care 5, no. 4 (2013): 420-26; Sy, Jann Adriel, Mark Mj Tan, and Lalit Kumar Radha Krishna, “A Review of Decision-making Models in End-of-life Care in Singapore,” *Clinical Case Reports and Reviews* 1, no. 8 (2015).

¹⁷ Chang et al., 117-28; Lalit Kumar Radha Krishna et al., “Perceptions of Quality-of-life Advocates in a Southeast Asian Society,” *Diversity & Equality in Health and Care* 14, no. 2 (2017); Sng, David et al., “Perspectives of Singaporean Patients and Caregivers towards Quality of Life or Quantity of Life with Disease-modifying Treatment in the End-of-life Setting,” *Proceedings of Singapore Healthcare* 26, no. 1 (2016).

¹⁸ Shin Wei Sim, and Lalit Kumar Radha Krishna, “Respecting the wishes of incapacitated patients at the end of life,” *Ethics and Medicine* 32, no. 1 (2016):15-29.

¹⁹ Krishna, “Slippery Slope to Hastening of Death”; Chang et al., 117-28; Ho, Krishna and Yee, 932-37; Krishna and Menon, “Collusion on End of Life Care”; Yang, Krishna and Kwee, “Should Patients and Family Be Involved”, 52; Sy, Mark and Krishna; Tay, et al., “Advance Care Planning”, 665-74; Lalit Kumar Radha Krishna, Jason Te Tay, Deborah S. Watkinson, and Chung Pheng Alethea Yee, “Advancing a Welfare-Based Model in Medical Decision.” *Asian Bioethics Review* 7, no. 3 (2015): 306-20; Loh, Alvona Zi Hui, “The Ramifications of At-Own-Risk Discharges in the Palliative Care Setting,” *Journal of Palliative Care & Medicine* 5, no. 4 (2015); Chan, Brian YI, Joanne Ey Chin, and Lalit Kumar Radha Krishna, “The Welfare Model: A Paradigm Shift in Medical Decision-making,” *Clinical Case Reports and Reviews* 1, no. 9 (2015); Lalit Kumar Radha Krishna, “The position of the family of palliative care patients within the decision-making process at the end of life in Singapore,” *Ethics and Medicine* 27, no. 3 (2011): 183-90; Lalit Kumar Radha Krishna, “Accounting for Personhood in Palliative Sedation: The Ring Theory of Personhood,” *Medical Humanities* 40, no. 1 (2014): 17-21; White, Douglas B. et al., “Prevalence of and Factors Related to Discordance About Prognosis Between Physicians and Surrogate Decision Makers of Critically Ill Patients,” *Jama* 315, no. 19 (2016): 2086.

²⁰ Phua, Jason et al., “End-of-Life Care in the General Wards of a Singaporean Hospital: An Asian

competent patients were aware of their prognosis and the ‘true’ nature of their conditions at the end of their life.²¹ This data is showing the compromise to the concept of informed consent and the consequent valid use of MAID.

Thanatophobia in local culture also limits discussions about death and dying and hinders discussions not only about goals of care and places of care but also about the palliative care options available.²² The Duty to Maintain Hope prevents discussions about treatment alternatives whilst the Duty of Non-abandonment would see discussions and acceptance of palliative medicine as abandoning hope and ‘curative’ options.²³ These limitations upon information provided to patients questions the viability of consent for end of life procedures.

b. Psychosocial support

Local healthcare and social support systems also impact care determinations at the end of life. Within the Singapore context, where despite significant governmental support with care subsidies and support for helpers at home and increased social support, patients often feel a burden towards their family who must contend with the costs of care at home and inevitable changes to their household and work routines.²⁴ In

Perspective,” *Journal of Palliative Medicine* 14, no. 12 (2011): 1296-301.

²¹ Chong, et al., 420-26.

²² Phua, et al., 1296-301; Low, James A., W. C. Ng, K. B. Yap, and K. M. Chan, “End-of-life issues-preferences and choices of a group of elderly Chinese subjects attending a day care centre in Singapore,” *Annals of the Academy of Medicine Singapore* 29, no. 1 (2000):50-6; Chan, Carol K. L., and Matthew K. Yau, “Death Preparation among the Ethnic Chinese Well-Elderly in Singapore: An Exploratory Study,” *OMEGA - Journal of Death and Dying* 60, no. 3 (2010): 225-39.

²³ Ho, Krishna and Yee, 932-37; Phua, et al., 1296-301; Liu, Qiang, “Core Culture Values and Beliefs of Singapore,” *American Journal of Culture and Philosophy* 2, no. 2 (2007); Doran, Christine, “The Chinese Origins of Democracy: Dynamic Confucianism in Singapore,” *Nebula* 7, no. 4 (2010): 47-53; Foo, Aaron S.C., Tze Wee Lee, and Chai Rick Soh, “Discrepancies in End-of-Life Decisions between Elderly Patients and Their Named Surrogates,” *Annals of the Academy of Medicine Singapore* 41, no. 4 (2012): 141-53; Toh, Han Chong, “Providing Hope in Terminal Cancer: When Is It Appropriate and When Is It Not?” *Annals of the Academy of Medicine Singapore* 40, no. 1 (2011): 50-5; Tan, T. K., F. C. Teo, K. Wong, and H. L. Lim, “Cancer: To Tell or Not to Tell?” *Singapore Medical Journal* 34, no. 3 (1993): 202-3; Low, James, “Reducing Collusion Between Family Members and Clinicians of Patients Referred to the Palliative Care Team,” *The Permanente Journal* 13, no. 4 (2009); Ong, W. Y., C. M. Yee, and A. Lee, “Ethical Dilemmas in the Care of Cancer Patients near the End of Life,” *Singapore Medical Journal* 53, no. 1 (2012): 11-6.

²⁴ Krishna, “Position of the family of palliative care patients”, 183-90; Krishna, “The Ring Theory of Personhood”, 17-21; Lalit Kumar Radha Krishna, “Nasogastric Feeding at the End of Life: A Virtue Ethics

the face of obligations to place the family's interests over individual interests of patients, these factors could create enduring and coercive influences upon decisions for MAID.²⁵

c. Consistency of requests to die

A qualitative study by Mak and Elwyn revealed the core of its subjects' apparent desire for euthanasia to be their yearning for "care, connectedness and respect" rather than a genuine wish to discontinue living.²⁶ There is increase in local data, however, that suggests that goals of care evolve and interests change over the course of an illness.²⁷ Alsuwaigh and Krishna found that concepts of personhood amongst patients and their loved ones in a Singaporean oncology centre evolve with changing situations, physical limitations and time.²⁸ Kwek and Krishna's study of personhood over the course of an illness underline the ability of patients and their families to adapt to their evolving conditions and reframe their idea of dignity.²⁹ This raises questions about the consistency of the desire to hasten death given time and effective support further weakening the position of MAID.

Approach," *Nursing Ethics* 18, no. 4 (2011): 485-94; Lalit Kumar Radha Krishna, "Best Interests Determination within the Singapore Context," *Nursing Ethics* 19, no. 6 (2012): 787-99; Lalit Kumar Radha Krishna, "Personhood within the Context of Sedation at the End of Life in Singapore," *Case Reports*, (2013): 1-5; Lalit Kumar Radha Krishna, and Rayan Alsuwaigh, "Understanding the Fluid Nature of Personhood - the Ring Theory of Personhood." *Bioethics* 29, no. 3 (2014): 171-81; Kwon, Soonman, "Health Care Financing in Asia," *Asia Pacific Journal of Public Health* 23, no. 5 (2011): 651-61.

²⁵ Shin and Krishna, 15-29.

²⁶ Chien, Wai-Tong, and R.c.s. Lam, "Attitudes of Acutely Ill Patients Towards Euthanasia in Hong Kong," *The Open Nursing Journal* 1, no. 1 (2007): 1-5.

²⁷ Chang et al., 117-28; Krishna and Alsuwaigh, "Understanding the Fluid Nature of Personhood", 171-81; Lalit Kumar Radha Krishna et al., "The Influence of the Family in Conceptions of Personhood in the Palliative Care Setting in Singapore and Its Influence Upon Decision Making," *American Journal of Hospice and Palliative Medicine* 31, no. 6 (2014): 645-54.

²⁸ Krishna, "Slippery Slope to Hastening of Death?".

²⁹ Lalit Kumar Radha Krishna, "Personhood within the Context of Sedation", 1-5; Lalit Kumar Radha Krishna, and Suat Yee Kwek, "The Changing Face of Personhood at the End of Life: The Ring Theory of Personhood," *Palliative and Supportive Care* 13, no. 04 (2014): 1123-129.

2. Ethical Considerations

There are several ethical issues that relate to MAID; however, here the focus remains confined to the issue of rights.

a. Validity of the right to die

Proponents for PAS/E assert that competent terminally ill patients diagnosed with ‘intractable suffering’ should have the ‘right to die’ and decide the time and the way they die. To begin, the phrase ‘the right to die’ can mean at least five different things to different people: i. the right to refuse life-sustaining treatment which is burdensome or futile; ii. the right to refuse life-sustaining treatment for any reason; iii. the right to commit suicide for ‘rational’ reasons; iv. the right to obtain help in committing suicide; or v. the right to be killed by a doctor at your request.³⁰

On the surface, the right to refuse life-sustaining treatment, which is burdensome or futile, is acknowledged in Singapore. However, caveats exist, particularly within Singapore’s Advance Medical Directive (AMD) Act, which limit the rights of terminally ill patients to refuse life prolonging treatment when incapacitated. Under the AMD Act, patients cannot refuse basic hydration nor palliative care. This raises the question of rights.

Firstly, proponents of MAID would argue that the right to die is a natural inalienable right of all rational human beings. Natural rights are developed as a proclamation of liberty, to be used to guarantee freedom from attacks on one’s life, dignity or property. They apply equally to each individual, are unconditional and impose on others a duty to respect them. Yet does the right to die actually exist as part of natural rights? Proponents of MAID argue that the right to die protects against a loss of dignity, which is enshrined in this natural right. Careful study of the Principle of Freedom which is invoked by proponents of MAID in support of their position is clear that there are limits to the right to function autonomously. One caveat drawn from extrapolation of Mill’s assertions that “the principle of freedom cannot require that he should be free not to be free” must be the similar prohibition to self-termination

³⁰ Wyatt J, *Matters of life and death* (Nottingham, England: Inter-varsity Press, 2009).

given that such an action irreversibly surrenders all future ability to function autonomously.³¹ Death does not preserve individual autonomy.

Secondly, welfare rights - defined as entitlements to opportunities or goods to be provided or respected by others, are not universally applicable and are culturally dependent and societally endowed. This leaves attempts to advocate for the right to die, under the aegis of welfare rights, a failure.

b. The duty of care

What should the duty of the physician be when a patient's suffering is intractable, prognosis short, and the competent patient is fully informed of their condition, and then requests for their death to be hastened in order to relieve suffering? Krishna and Chin suggest that the overarching goals of care "*at the very end of life when the rapid attenuation of treatment options and the eminence of the final outcome indicate that the goals of care have irretrievably shifted from cure to palliation*" must be focused upon "*comfort and maximizing the quality of life of the patient without hastening death or prolonging the dying phase.*"³² Building upon Krishna and Chin's concept of the Duty of Palliative Care (DoPC), the Palliative Medicine Imperative (PMI)³³ acknowledges the exigencies of end of life care determinations and the difficulties of determining how to preserve the welfare of the patient. The PMI upholds the need to confine practice to legally, societally, professionally and institutionally-sanctioned practice and determines that the overall goals of care must be focused upon maximizing the patient's welfare as determined by a multidisciplinary Palliative Care team (MDT). This would ensure that laws are obeyed, and MAID cannot be applied as there is no conceptual difference between MAID and PAS/E.

Determining the overall welfare of a patient is complex. Chan et al, Krishna et al and Krishna, Murugan and Quah argue for holistic use of an MDT who must consider

³¹ Low, "Reducing Collusion"; Low, J. A., and W. S. Pang, "Is Euthanasia Compatible with Palliative Care?" *Singapore Medical Journal* 40, no. 5 (1999): 365-70.

³² Lalit Kumar Radha Krishna, Jacqueline Chin, "Palliative Sedation within the Duty of Palliative Care within the Singaporean Clinical Context," *Asian Bioethics Review* 3, no. 3 (2011): 201-15.

³³ Lalit Kumar Radha Krishna, "Palliative Care Imperative: A Framework for holistic and Inclusive Palliative Care," *Ethics and Medicine* 29, no. 1 (2013): 41-61.

what care can be practically provided to the patient, their psychosocial, cultural, clinical, financial and familial context, and prevailing clinical and professional standard prevailing laws and societal norms when determining how the overall welfare of the patient can be preserved.³⁴ Thus, the duty of care towards patients with intractable suffering is to ensure comfort by employing measures like palliative sedation instead of taking the “easy way out” using MAID.

3. Evidence-based review of MAID

MAID pivots upon 4 key elements, which include (a) effective prognostication of a life expectancy of less than 6 months, (b) a diagnosis of intractable suffering, (c) the ability to provide informed and consistent consent, and (d) the patient’s request must be free of coercion. We will use clinical data to evaluate these 4 aspects.

a. Prognostication

Valid application of MAID pivots on a determination that the patient requesting MAID is terminally ill and has a prognosis of less than 6 months. Yet Clinical Predictions of Survival and prognostic tools within the palliative oncology setting, such as the Palliative Performance Index, Palliative Prognostic Score, PIPs A, PIPs B, and D-PaP, show no more than 70% accuracy. The efficacy of these processes is further hamstrung by the presence of comorbidities and organ failure that alter disease trajectories.³⁵

³⁴ Ibid; Chan, Chin, and Krishna, “The Welfare Model”; Krishna, et al., “Advancing a Welfare-Based Model,” 306-20; Lalit Kumar Radha Krishna, Sumytra Menon, and Ravindran Kanesvara, “Applying the Welfare Model to At-own-risk Discharges” *Nursing Ethics* 24, no. 5 (2015): 525-37; Lalit Kumar Radha Krishna, Vengadasalam Murugam, and Daniel Song Chiek Quah; Beng, Tan Seng et al., “The Suffering Pictogram: Measuring Suffering in Palliative Care,” *Journal of Palliative Medicine* 20, no. 8 (2017): 869-74; Al-Shahri, Mohammad Zafir, Abdelmoneim M. Eldali, and Omar Al-Zahrani, “Prevalence and Severity of Suffering among Patients with Advanced Cancer,” *Supportive Care in Cancer* 20, no. 12 (2012): 3137-140; Ruijs, Cees Dm, Ad Jfm Kerkhof, Gerrit Van Der Wal, and Bregje D. Onwuteaka-Philipsen, “The Broad Spectrum of Unbearable Suffering in End-of-life Cancer Studied in Dutch Primary Care,” *BMC Palliative Care* 11, no. 1 (2012).

³⁵ Penel, Nicolas, Sylvain Dewas, Aurélien Hoffiman, and Antoine Adenis, “Cancer-associated Hypercalcemia: Validation of a Bedside Prognostic Score,” *Supportive Care in Cancer* 17, no. 8 (2009): 1133-135; Maltoni, M. et al., “Prospective Comparison of Prognostic Scores in Palliative Care Cancer Populations,” *The Oncologist* 17, no. 3 (2012): 446-54; Beddhu, Srinivasan et al., “A Simple Comorbidity

Whilst in reality inaccuracies in prognostication spurs more conservative actions and overestimation of prognosis that would mean that MAID would be likely applied further down the disease trajectory, the concern about the inaccuracies of prognostication revolve around the perceptions surrounding the implications of making a prognostication. Some may defer prognostication or make an overestimation, thus jeopardizing viable treatment options for patients, such as effective end of life in the belief that it may thwart efforts to employ MAID. On the other hand, others may underestimate prognosis simply to allow use of MAID. Variations in prognosis will compromise care.

b. Consent

Aside from the effects of collusion, circumnavigation of direct patient involvement, familial determinations and thanatophobia; intractable suffering, growing levels of delirium and the presence of depression, fatigue and poor concentration amongst the terminally ill, especially those suffering from intractable suffering, must be seen as coercive factors that compromise effective decision making and the viability of informed consent.³⁶

IV. Practical Considerations

Decriminalizing suicide and the abetment of suicide

Key to any effort to legalise MAID in Singapore must be the decriminalization of suicide, the abetment of suicide and the prohibition of physicians assisting suicide.³⁷

Scale Predicts Clinical Outcomes and Costs in Dialysis Patients,” *The American Journal of Medicine* 108, no. 8 (2000): 609-13.

³⁶ Krishna, “Slippery Slope to Hastening of Death?”; Shin and Krishna, “Wishes of Incapacitated,” 15-29; Krishna, “Nasogastric Feeding at the End of Life,” 485-94; Krishna, “Position of the Family of Palliative Care Patients,” 183-90; Krishna and Chin, “Duty of Palliative Care,” 207-15; Krishna, “Best Interests Determination,” 787-99; Krishna, “Palliative Care Imperative,” 41-61; Lalit Kumar Radha Krishna, “Decision making at the end of life: A Singaporean Perspective,” *Asian Bioethics Review* 3, no. 2 (2011): 118-126; Lalit Kumar Radha Krishna, and Benjamin Capps, “Opioid Use at the End of Life: Working out the Physician’s Intentions,” *Indian Journal of Medical Ethics*, (2011); Lalit Kumar Radha Krishna, “Addressing the Concerns Surrounding Continuous Deep Sedation in Singapore and Southeast Asia: A Palliative Care Approach,” *Journal of Bioethical Inquiry* 12, no. 3 (2015): 461-75; Lalit Kumar Radha Krishna, “Consent in Terminal Sedation,” *Indian Journal of Medical Ethics*, no. 3 (2010): 161-4.

Also required would be a review of the Advance Medical Directive Act that prohibits the acceleration of the dying process.³⁸

Menon,³⁹ the Chief Justice of Singapore, rightly points out that decisions to approve MAID cannot be a matter for the courts but for the society to determine. Here the weight of public opinion remains firmly on the side of not supporting any procedures that hastens death.⁴⁰

Impact upon Palliative Care

What would the role of Palliative Care be if MAID is legalised and what would the effect be upon the development of end of life care in Singapore? Some commentators dismiss the notion that Palliative Care and MAID cannot co-exist, highlighting that Dutch and American Palliative Care communities have continued to flourish despite the legalisation of PAS/E.

However, contextualizing the issues to the local setting gives us pause. Consider the situation with regards to continued opioid-phobia in Singapore. Opioids, and specifically morphine, played a central role in the Death Houses along Sago Lane that catered for care of the destitute and dying in post war Singapore until they were banned in 1961.⁴¹ These associations continue to affect introduction of Palliative Care services and opioid use locally. It follows that any association with MAID will likely tarnish the position of Palliative Medicine amongst local patients.

The next consideration would be to consider the role of Palliativists in the operationalization of a legalised approach to MAID. Who better to provide second opinions to confirm not just the wishes of the patient but their terminal condition and

³⁷ *Penal Code*, Singapore Statutes Online <https://sso.agc.gov.sg/Act/PC1871#pr309->; *Penal Code*, Singapore Statutes Online <https://sso.agc.gov.sg/Act/PC1871#pr109->.

³⁸ *CHAPTER XVI Culpable Homicide*, Singapore Statues <https://sso.agc.gov.sg/Act/PC1871#pr299->.

³⁹ Sumytra Menon, "Euthanasia: A Matter of Life or Death?".

⁴⁰ Koh TBT, and Solomon RM, *Is It Time for Singapore to Consider a Right-to-die Bill?* IPSCCommons <https://www.ipsccommons.sg/debate-is-it-time-for-singapore-to-consider-a-right-to-die-bill/>.

⁴¹ Lee J, *Mothership: Chinatown's Sago Lane was once a street of death houses, they were a necessary part of life in the past*, Mothership <https://mothership.sg/2017/07/chinatowns-sago-lane-was-once-a-street-of-death-houses-they-were-a-necessary-part-of-life-in-the-past/>.

the intractability of their symptoms? Would the ‘active’ medical role within MAID also fall upon the shoulders of the Palliative Care fraternity?

On this matter the Singapore Hospice Council is clear. Aside from stressing the need to respect the values of Singaporean society as enshrined by the laws of the land, the Singapore Hospice Council stresses that Palliativists in Singapore ‘intend neither to hasten nor postpone death.’⁴² This position is supported by the paper on Euthanasia and Physician-Assisted Suicide set out by the International Association for Hospice and Palliative Care, and the International Children’s Palliative Care Network position, which states that “enabling good quality of life cannot include hastening death, and we do not believe that euthanasia or physician-assisted suicide is part of children’s palliative care .”⁴³ Echoing statements forwarded by the European Association for Palliative Care, the World Medical Association, the American Nursing Association, the American Academy of Hospice and Palliative Care, the National Hospice and Palliative Care Organization, the Hospice and Palliative Nurses Association, Palliative Care Australia, Canadian Society of Palliative Care Physicians and the British Medical Association, the Singapore Hospice Council is concerned that adoption of PAS/E and its iterations would propagate the notion that “the intentional ending of one’s life as a societally mandated good” and change the very nature of Palliative Care, Nursing and Medicine as a whole.⁴⁴

⁴² *Definition of Palliative Care*, World Health Organization <http://www.who.int/cancer/palliative/definition/en/>.

⁴³ Lima, Liliana De et al., “International Association for Hospice and Palliative Care Position Statement: Euthanasia and Physician-Assisted Suicide,” *Journal of Palliative Medicine* 20, no. 1 (2017): 8-14; Drake R, Hain R, McNamara K, “International Children’s Palliative Care Network (ICPCN): Position Statement on the practice of Euthanasia and Assisted Suicide,” 2014, <http://www.icpcn.org/wp-content/uploads/2013/07/ICPCN-Position-Paper-on-Euthanasia-in-Childrens-Palliative-Care.pdf>.

⁴⁴ *World Medical Association: Statement on Physician Assisted Suicide*, World Medical Association <https://www.wma.net/policies-post/wma-statement-on-physician-assisted-suicide/>; *Position Statements Euthanasia, Assisted Suicide and Aid in Dying*, American Nurses Association https://www.nursingworld.org/~4af287/globalassets/docs/ana/ethics/euthanasia-assisted-suicideaid-in-dying_ps042513.pdf; *Statement on Physician Assisted Dying*, American Academy of Hospice and Palliative Medicine <http://aahpm.org/positions/pad>; *Commentary and Resolution on Physician Assisted Suicide*, National Hospice and Palliative Care Organization https://www.nhpco.org/sites/default/files/public/PAS_Resolution_Commentary.pdf; *Position Statement on Legalization of Assisted Suicide*, Hospice and Palliative Nurses Association https://www.theirisproject.net/uploads/7/8/4/1/78413882/hpna_legalization_of_assisted_suicide_position_statement_080311.pdf; *Position Statement on Euthanasia and physician assisted suicide*, Palliative Care Australia http://palliativecare.org.au/wp-content/uploads/dlm_uploads/2015/08/20160823-Euthanasia-and-Physician-Assisted-Suicide-Final.pdf; *Position on Euthanasia and Assisted Suicide*, Canadian Society of Palliative Care Physicians <http://www.cspcp.ca/wp-content/uploads/2014/10/CSPCP-Position-on-Euthanasia-and-Assisted-Suicide-Feb-6-2015.pdf>; *Physician-assisted Dying*, British

V. Conclusion

Proponents of PAS/E have introduced the term “Medical Aid-In-Dying (MAID),” to circumnavigate terms like “suicide” and “killing.” Depicted as a neutral means of alleviating the intractable suffering of competent terminally ill patients at a time, place and manner of their choosing, MAID attempts to suggest that patients will die as a result of their disease sans “killing” or “suicide.” MAID is portrayed as a means for a patient to ‘regain’ control over their destiny. However, all the key elements required for the effective use of MAID fail to ameliorate concerns about the slippery slope to abuse whilst use of euphemisms to replace words traditionally associated with death and dying fail to persuade us that MAID is viable within the Singaporean context.⁴⁵ It is in fact conceptually identical to PAS/E.

A further lesson to be learnt is that efforts to translocate clinical evidence from one setting to another need to be considered holistically with careful reference to local clinical, cultural and social realities. Data taken from America and the Netherlands does not appear immediately applicable to the local context and experience with this review underlines the need for careful scrutiny and contextualising of extrapolated data. Perhaps this is especially so for data that would affect public policy.

Received: October 15, 2018

Revised: February 18, 2019

Accepted: February 25, 2019

Medical Association <https://www.bma.org.uk/advice/employment/ethics/ethics-a-to-z/physician-assisted-dying>.

⁴⁵ Wilkes, Lesley, Kate White, and Neal Tolley, “Euthanasia: A Comparison of the Lived Experience of Chinese and Australian Palliative Care Nurses,” *Journal of Advanced Nursing* 18, no. 1 (1993): 95-102; Lalit Kumar Radha Krishna, “Decision making at the end of life: A Singaporean Perspective,” *Asian Bioethics Review* 3, no. 2 (2011): 118-126.