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Living, Dying, Death And Advance Directives

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A minimum criterion for a doctor must surely be that he can tell the difference between a living or a dead patient. As recently as 1967, Feinstein[1] could describe a physician who possesses clinical judgement as: "He knows the many clinical distinctions that tell him when death is imminent or hope abundant; when to treat, when to wait, when to stop treatment; when to treat aggressively for cure, palliatively for relief and consolingly for comfort." The nature of Medicine has changed dramatically since then. With the ability to transplant the kidneys, cornea, heart, lungs, bone marrow, liver, pancreas; implant prosthetic heart valves, pacemakers, joints, lenses in the eye; and with gene therapy and cloning on the not too distant horizon, the decisions on when to stop treatment and when to treat have become increasingly difficult. "Life support" has developed to such an extent that "Death" has to be legally defined in many countries.

With the technical advances, the attitude (and sometimes the training) of Physicians has also changed. The old teaching "*Guerir quelquefois* - to cure occasionally, *Soulager souvent* - to relieve often, *Consoler toujours* - to comfort always" and not to "strive to keep alive", has given way to a gung-ho "Prolong life at all costs - We have the technology". This is particularly true of in-hospital care. Many now think that "dying patients in hospitals frequently receive unwanted interventions, ..which cause unnecessary discomfort, including daily laboratory tests, regular radiographic examinations, frequent determination of vital signs, aggressive pulmonary hygiene, frequent turning, .."[2].

Other significant changes have occurred. The commercialisation and cost of medicine, the loss of absolutes in morality, indeed the dominance of pluralism such that ethical issues are discussed without firm foundations, these have all led to fewer patients (or their relatives) saying "Doctor, you do what you think is best - Sir".

There has been a strong reaction to these changes. In many countries, this has come in the form of pressure for legislation to permit euthanasia and/or assisted suicide, both of which require active intervention, most often by a doctor. Tragically, even when the law forbids it, the Dutch experience suggests that such practices are not uncommon, and the much publicised actions of Dr "Death" Kevorkian show that there is no fear of successful prosecution. The confusion and debate surrounding this area will not be within the scope of the present paper. Fortunately, enough common sense remains in Singapore to reject this option.

An alternative reaction is the advance directive, the history of which has been reviewed recently in this journal[3]. This differs (significantly, in our view) from euthanasia in being a passive withdrawal or refusal of medical intervention, via a legal written instruction (the "living will"), or by appointing a designated person to give such instructions on the patient's behalf (the "advance proxy"). Thus it is strictly limited in its applicability to when the person does not have the capacity to make such a decision, and this is yet another significant difference from euthanasia and assisted suicide. Many doctors are already familiar with the practical outworking of such decisions of withdrawal/refusal of treatment when faced with an incurable illness. The decision causes no problems when the patient is competent. When it is sufficiently clear that further treatment is futile, the reaction "I don't want any more treatment, I would like to go home" is accepted. The development of good hospice care has helped provide for this option; and most hospices are careful to dissociate themselves from euthanasia or assisted suicide. Even when the patient is a young child, and lacks the legal capacity to decide to refuse treatment, the practice of the parents and doctors agreeing to discontinue further futile treatment is accepted as good medical practice.

However, any legislative change on life and death issues does cause concern. The survey[4] in this issue (and the medical students, and their mentors, are to be commended for their efforts) illustrates some of these concerns already with the soon to be publicised advance medical directive in Singapore. Is this a possible thin end of the wedge to let in enthanasia? Our opinion is that the advance directive, together with good hospice care, will reduce the pressure for euthanasia. The advance directive, in our view, will permit an incapacitated patient's wishes to be given due regard, and restore respect of the patient's autonomy, which other competent and legally capable patients already have, and do exercise. Doctors will still be important in the decision process, but no longer the sole decision makers.

Is this an attempt by Government to reduce health care costs? We do not think so. Cynics have observed that those who can most afford to, do get the most unnecessary intervention. The experience in the UK and the USA suggests that it is not cost concerns, but

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highly publicised exceptional cases, in the absence of clear legislation, that has led to some of the strongest pressure against unnecessary medical intervention. Our concern is that the many safeguards in the Singapore version of the advance medical directive, soon to be implemented, may in fact make it too cumbersome initially, and that the reactive changes later on will remove too many of these safeguards. But that remains to be seen.

Laws on abortion, in Singapore and other countries, have clearly alarmed some who hold deep convictions, that flood gates will be opened to further devaluation of human life. However, we have some reasons to be optimistic. While no legislator's life will be terminated by abortion (by definition), the possibility that any law on the advance directive or euthanasia may directly affect those who legislate, will probably uniquely focus their mind to clearer thinking with more, rather than less, safeguards.

The above are the personal views of the authors, and do not reflect necessarily the official views of their institutions nor their religious affiliations.

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