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The recent Karen Ann Quinlan's case in the United States had sparked off a renewed round of the never-ending debate on Euthanasia. The views are still as divergent as when it first started, although somewhat modified by the new concept of brain death and modern resuscitation techniques. Even the courts held different opinions.

Organized movements to legalise voluntary Euthanasia commenced in England when the Voluntary Euthanasia Legislation Society (now called the Euthanasia Society) was formed in 1932 under the presidency of Lord Moynihan, President of the Royal Collage of Surgeons. Its members included famous names like Julian Huxley, H. G. Wells and G. B. Shaw. A Voluntary Euthanasia Bill was twice introduced in the parliament in 1936 and 1950 but was defeated on both occasions. There is evidence that renewed efforts are being made by the Society to have the Bill passed in the mid-1980s.

A similar movement in America was carried out by the Euthanasia Society of America founded in 1938. Again an attempt at introducing a Bill on Euthanasia was defeated.

Even before these, F. A. W. Grisborne, writing in «Democracy on Trial» in 1928 said:

«In the case of the victim of incurable physical disease, doctors, not less than two in each case, should be empowered to administer an opiate sufficiently strong to afford lasting relief. The question should be left entirely to medical experts to decide, and there would be no need to consult the sufferer. There would then be no cause for after-regrets, and the survivors of the departed would not be haunted by painful

memories. Rather, they would feel comforted by the thought that one who had been dear to them had been spared unnecessary suffering.

Thus the main argument for Euthanasia is to relieve pain and suffering in a hopeless patient. We know too well the excruciating pain and agony that a terminal cancer patient suffers where the chances of returning to normal life are nil; or the helpless state of a patient severely crippled by recurrent heart attacks. When the outlook is grim, to prolong life is to prolong pain and suffering to the patient, and to increase worries and burden, financially, physically and mentally to the relatives. I have witnessed in several instances where the descendants and relatives toiled and rallied round the incurable sick — a severe diabetic with renal and cardiac complications, a paralytic from repeated strokes, a terminal cancer patient. Each time the condition of the patient took a turn for the worse, they had to abandon work to take care in turn. This could go on for a long period, as modern science has advanced to such a stage that life can be prolonged in the face of odds. But it is important to realize what quality of life is being preserved. The physician must decide whether it is worthwhile to continue the futile effort at high costs. If one holds the view that life is the immortal soul imprisoned in a mortal body, death is but the release of the soul from the body into eternal after-life. Is it not then logical and humane to effect the release earlier?

However, to institute any deliberate action or procedure to hasten death is still unlawful in many countries, whether consent is given by the patient or not. It is illegal to consent to grievous hurt to your body or to be killed, according to Singapore Statutes.

Further, positive Euthanasia or deliberate mercy-killing, in the opinion of many physicians would severely undermine the basic trust that the patient places in his doctor to get better alive. It is the experience of those who are looking after the dying that these patients seldom wanted to die; although in fits of depression or under distress of pain one might ask to be terminated. But once the crisis was overcome, they were glad to have survived and regretted wanting to die. Another argument against voluntary Euthanasia is that the doctors' opinion might be in error, and the estimation of life span is not accurate. There are many examples where a patient was told to expect a fatal outcome soon, but went on living for a long time. Even in the case of Karen Quinlan, when before the court trial the doctors were of the opinion that she would die without the help of the respirator, but after the Supreme Court decision she went on living independently after being weaned off the respirator.
It is likely that the deliberate ending of life is going to remain unlawful for a long time until the society changes its concept of death and the dying. No matter how much safeguard might be put in the legislature, doubts will be cast on the validity of the consent and the possibility of the patient revoking his option.

On the other hand, negative Euthanasia or the withholding of resuscitative treatment and withdrawing of life-support systems in hopeless cases has gained wide support. This has not met with any religious, legal or ethical objections.

Pope Pius XII declared in 1957: «Respirators and other mechanical aids are extraordinary systems for prolongation of life and that the physician is only under an obligation to institute ordinary and not extraordinary measures. If the physician is concerned that there is no hope of reviving a patient who is virtually dead, then he is under no obligation to continue with these measures».

The Supreme Court of New Jersey in the Karen Quinlan case expressed the opinion: «Upon the concurrence of the guardian and family of Karen, should the responsible attending physicians conclude that there is no reasonable possibility of Karen ever emerging from her present comatose condition to a cognitive, sapient state and that the life-support apparatus now being administered to Karen should be discontinued, they shall consult with the hospital «Ethics Committee» or like body of the institution in which Karen is then hospitalised. If that consultative body agrees that there is no reasonable possibility of Karen ever emerging from her present comatose condition to a cognitive, sapient state, the present life-support systems may be withdrawn and said action shall be without any civil or criminal liability therefore, on the part of any participant, whether guardian, physician, hospital or others ³». This poses other difficulties like referring cases to the «Ethics Committee» which could become bureaucratic and unrealistic. The court also recognised that «humane decisions against resuscitative or maintenance therapy are frequently a recognised de facto response in the medical world to the irreversible, terminal, pain-ridden patient, especially with familial consent».

Many hospitals had adopted the ‘no code’ system, that is, to withhold resuscitative treatment in a terminally ill patient but only after consent from relatives is obtained. It is essential for the physician

in charge to hold frank discussion with the relatives, and in suitable cases the patient himself, about the probable outcome of a progressive incurable illness. By putting the situation squarely before them, the relative will understand and agree to the inaction that follows.

The Ministry of Health had set up a special 'ethics committee' to issue advice and guidelines for medical practitioners to follow on the subjects of human experimentation and criteria of death. In Singapore, death is not defined legally but left to medical judgement. Death is declared on meeting the following criteria:

1. Loss of response to the external environment (loss of all reflexes).
2. Continuous falling of blood pressure when it is not maintained artificially.
3. No spontaneous respiration or heart beat.
4. Linear EEG for 24 hours with maximum stimulation. This is done by a neurologist experienced with intensive care and EEG.

Two physicians of consultant status, at least one of them a clinical consultant must concur before life-supporting systems can be withdrawn. This is accepted by law.

The advent of organ transplantation had made necessary the introduction of the concept of brain death against the conventional definitions of death. This enabled physicians to withdraw life-supporting systems from patients upon meeting the criteria of brain death. This is a form of negative Euthanasia not only beneficia to the patient himself but also to the recipients of the organ donation.

Legislation of voluntary Euthanasia will continue to be resisted by the Society and would not gain wide support. On the other hand there is wide pread acceptance that physicians may cease to initiate new treatment for complications, and withhold life-supporting procedures in a terminally ill and irrecoverable patient. However, before reaching that decision it is well advisable for the physician in charge to confer with his colleagues and to obtain consent from the relatives after explanation of the situation.

Though there may be emergency situations in which an immediate decision is demanded without time for consultation, as long as the physician acts in a reasonable manner with due care and attention, justifiable in his action, the Courts will view the intention favourably and there is no fear of a malpractice suit.