DECRIMINALISING PHYSICIAN-ASSISTED SUICIDE IN SINGAPORE

This article evaluates the primary reasons for and against the decriminalisation of physician-assisted suicide of terminally-ill patients. It contends that the benefits of decriminalisation outweigh the harms, and sets out to formulate legislation for adoption in Singapore based on the best features of the regulatory models devised by the Netherlands, Oregon and the Northern Territory of Australia.

TOH Puay San[*]
LLB (Hons) (National University of Singapore);
Deputy Public Prosecutor, Attorney General's Chambers, Singapore.

Stanley **YEO**
LLB (Hons) (University of Singapore),
LLM (Wellington), LLM, PhD, LLD (Sydney);
Professor of Law, National University of Singapore.

I. Introduction

1 Every human being must confront death at some point in their lives. Due to the advances in modern medical technology, ways have been found to prolong life and delay death. However, this does not necessarily result in human lives being enriched in a full and meaningful manner because, in some cases, it merely lengthens the physical or biological existence of a person. Many people do not fear death as much as they fear the "tragic figure"[1] they may become before death. In order to minimise their suffering and to honour their dignity, these people should be afforded more control over the timing and manner of their deaths.

2 In Singapore, the Advance Medical Directive Act[2] gives Singaporeans some control over their deaths by allowing a person of sound mind to sign an advance medical directive ("AMD") declaring that he or she does not wish to receive extraordinary life-sustaining

---

* The views expressed in this article are those of the author's alone, and not representative of the official views of the Attorney General's Chambers.

1 M Cheang, "Voluntary Euthanasia" (1977) 18 Singapore Medical Journal 265 at 266.

2 Cap 4A, 1997 Rev Ed.

treatment in the event of terminal illness. As our ageing population[3] grows, more measures need to be put in place to deal with end-of-life issues. Recently, Health Minister Khaw Boon Wan expressed that "ageing will throw up many more human stories of agony and suffering".[4] The Minister's remarks have spawned a public debate over whether voluntary active euthanasia ("VAE") should be legalised.[5] The Ministry of Health has announced plans to make the process of signing the AMD less complicated and to expand palliative care systems in Singapore. Importantly, however, it is observed that although optimum palliative care might minimise physical pain, it cannot remove the strong sense of helplessness and mental or emotional anguish that some patients experience as a result of the progressive deterioration of their bodies.[6]

3 This article argues that the options available to dying patients need to be increased. In the event that palliative care is unable to meet a patient's need of having his or her physical, mental or emotional health attended to adequately, the patient ought to have another option – physician-assisted suicide ("PAS"). While a patient has made the decision to end his or her life, he or she may not have the knowledge or means to do so in a painless and dignified manner and would require help. Assistance from physicians is more desirable than that from laypersons due to the former's medical training and access to drugs and equipment. Such assistance would also provide the patient with

3 It has been reported that between now and 2030, Singapore will witness an unprecedented profound age shift. In 2012, the first batch of baby boomers (those born between 1947 and 1964) will reach 65 years of age. By 2030, the number of residents aged 65 years or older will multiply threefold from the current 300,000 to 900,000. This means that one out of every five residents will be a senior. See further Committee on Ageing Issues, *Report on the Ageing Population* (3 February 2006), available at <http://www.mcys.gov.sg/successful_ageing/report/CAI_report.pdf> (accessed 23 January 2010).

4 P Forss, "S'pore to expand palliative care systems to deal with ageing population" Channel NewsAsia (14 October 2008), online: Channel NewsAsia, available at <http://www.channelnewsasia.com/stories/singaporelocalnews/view/382729/1/.html> (accessed 23 January 2010). Subsequently, Mr Khaw said that, while his Ministry encouraged "public discussion of death and end-of-life matters, it was not promoting PAS but palliative care for the terminally ill": S Khalik, "Health Minister against planned euthanasia talk" *The Straits Times* (25 April 2009) at p A18.

5 For example, see "Can you please kill me?" Special report on euthanasia, *Sunday Times* (26 October 2008) at p 6; R Basu, "Helping the dying with living" *The Straits Times* (5 November 2008) at p A8; "Euthanasia no substitute for palliative care" *The Straits Times* (6 November 2008) at p A26; R Basu, "Allowing euthanasia is no panacea" *The Straits Times* (15 November 2008), at p A25; J Yeo & M Mohan, "Right to die – or licence to kill?" *The Straits Times* (24 December 2008) at p A15.

6 E Jackson, "Death, Euthanasia and the Medical Profession" in *Death Rites and Rights* (B Brooks-Gordon *et al* eds) (Hart Publishing, 2007) at pp 44–46.

information about his or her prognosis and options, together with psychological support.[7]

4 The thrust of this article is that Singapore should decriminalise assisted suicide performed by physicians on terminally-ill patients facing imminent death, suffering unbearably, and holding the conviction that there is no other reasonable solution for the situation they are in. To this end, the authors have drafted a statute which incorporates the best features of the laws and regulations of three jurisdictions which have legalised PAS. In doing so, the authors should not be seen as arguing against improvements in palliative care and its utilisation; if patients prefer such care, their choice must be respected. Indeed, it is proposed that, as a pre-condition of PAS, a patient must undergo palliative care. Neither should this proposal to decriminalise PAS be viewed as a prelude to the decriminalisation of VAE. To this issue we now turn.

II. Decriminalising physician-assisted suicide but not voluntary active euthanasia

5 Among the many forms of medical intervention that shorten life, PAS and VAE are the methods that are most frequently discussed. Although they have much in common, it is contended that significant distinctions can be drawn and the legalisation of PAS is to be preferred over VAE. In both PAS and VAE, the patient forms an intention to die and the physician intentionally helps the patient to end his or her life. However, in PAS, the patient makes the final decision and performs the fatal act, that is, he or she is the "final causal actor"[8] in his or her own death. As such, PAS is an expression of the patient's autonomy, right to self-determination, and control. Conversely, although the patient similarly forms an intention to die in cases of VAE, the physician performs the final act and this creates a greater risk of physician malfeasance.

6 Accordingly, the underlying premise for advocating the decriminalisation of PAS is that it was the patients themselves, and not the physician, who had made the decision to terminate their own lives, and who had themselves done the act which terminated it. This double act by the patient of requesting assistance to commit suicide and following up with committing suicide, sets it apart from VAE where only the first act of the patient is present. In this regard, it is noteworthy that,

7 T Cipriani, "Give Me Liberty and Give Me Death" (1995–1996) 3 Journal of Law and Medicine 177 at 183. Such support excludes a physician encouraging his or her patient to opt for PAS. It will be proposed below that physicians should be legally prohibited from offering such encouragement.

8 N Gorsuch, *The Future of Assisted Suicide and Euthanasia* (Princeton University Press, 2006) at p 6.

in the Netherlands where both PAS and VAE by physicians are legalised, medical guidelines call for assisted suicide to be preferred over euthanasia because it "makes the patient's determination and willingness to take responsibility clearer".[9] This extra "firewall" renders PAS a limited activity which can be safely legalised and controlled without automatically leading to the legalisation of VAE.[10]

III. The current law and its constitutional validity

7 Although suicide is not an offence in Singapore, attempted suicide is by virtue of s 309 of the Penal Code.[11] That section, when read together with the abetment provision of s 107 of the Code, makes the abetting of attempted suicide a crime.[12] Where the attempt to commit suicide succeeds, s 306 of the Code makes the abetment of suicide a crime.[13]

8 PAS is criminalised in Singapore on account of these provisions. Thus, a physician who aids a patient in ending his or her life would be subject to prosecution. A physician's liability would not be absolved by s 88 of the Penal Code which provides that it is not an offence to commit an act which is not intended to cause death that was done with the consent of the person harmed, in good faith for the benefit of that person.[14] A physician engaged in PAS cannot plead this exception

---

9 Royal Dutch Medical Association (KNMG), *Position of the Federal Board of the KNMG concerning Euthanasia* (KNMG, 2003) at p 9.

10 This fact persuaded the House of Lords in its *First Report of the Select Committee on Assisted Dying for the Terminally Ill* (TSO, 2005) to recommend legalising only PAS in its second Assisted Dying Bill.

11 Penal Code (Cap 224, 1985 Rev Ed) s 309 reads: "Whoever attempts to commit suicide, and does any act towards the commission of such offence, shall be punished with imprisonment for a term which may extend to one year, or with fine, or with both."

12 Penal Code (Cap 224, 1985 Rev Ed) s 107 reads:

> A person abets the doing of a thing who –
>
> (a) instigates any person to do that thing;
>
> (b) engages with one or more other person or persons in any conspiracy for the doing of that thing, if an act or illegal omission takes place in pursuance of that conspiracy, and in order to the doing of that thing; or
>
> (c) intentionally aids, by any act or illegal omission, the doing of that thing.

13 Penal Code (Cap 224, 1985 Rev Ed) s 306 reads: "If any person commits suicide, whoever abets the commission of such suicide shall be punished with imprisonment for a term which may extend to 10 years, and shall also be liable to fine."

14 Penal Code (Cap 224, 1985 Rev Ed) s 88 reads: "Nothing, which is not intended to cause death, is an offence by reason of any harm which it may cause, or be intended by the doer to cause, or be known by the doer to be likely to cause, to any person for whose benefit it is done in good faith, and who has given a consent, whether express or implied, to suffer that harm, or to take the risk of that harm."

because he or she clearly intended by that act to cause the patient's death. Moreover, the defence of necessity under s 81[15] of the Penal Code is most unlikely to be extended to cover cases of PAS given the existence of specific provisions like ss 88 and 306 which render a physician criminally liable for PAS. Reference may also be made to the more severe penalty imposed under s 305 of the Penal Code compared to s 306,[16] where the deceased was under 18 years of age, insane, delirious, an idiot or intoxicated. The clear implication is that some recognition is afforded under s 306, by prescribing a lesser penalty compared to s 305, to the fact that the deceased in cases covered by s 306 could have requested (and thereby given consent to) assistance in committing suicide.

9 In sum, the law as it stands holds physicians who commit PAS criminally responsible. The consent of the patient to be killed, even if informed and freely given, is of no avail and, at most, serves to reduce the charge or the punishment but does not exculpate the physician altogether.

10 A possible method of decriminalising PAS in Singapore is to challenge the constitutional validity of ss 306 and 309 of the Penal Code. Although this has not been done here, there has been adjudication on this issue in India. In the Supreme Court of India case of *Gian Kaur v State of Punjab* ("*Gian Kaur*"),[17] the appellants who were convicted of the abetment of suicide under s 306 of the Indian Penal Code, had appealed against their conviction on the ground that s 306 was unconstitutional. They relied on the Supreme Court's earlier decision in *P Rathinam v Union of India*[18] which had held that s 309 was unconstitutional as it violated Art 21 of the Constitution of India.[19] They contended that if s 309 was unconstitutional, the closely related offence under s 306 would equally violate the Constitution. Consequently, the court had to reconsider its own decision in *P Rathinam v Union of India* and the constitutional validity of both s 306 and s 309 of the Indian Penal Code.

11 One of the issues the court deliberated over was whether Art 21, which provides for the protection of life and personal liberty, included the "right to die". The appellants contended that if such a right was

15 Penal Code (Cap 224, 1985 Rev Ed) s 81 reads: "Nothing is an offence merely by reason of its being done with the knowledge that it is likely to cause harm, if it be done without any criminal intention to cause harm, and in good faith for the purpose of preventing or avoiding other harm to person or property."

16 Penal Code (Cap 224, 1985 Rev Ed) s 305 provides for the death penalty or imprisonment for life, compared with 10 years' imprisonment under s 306.

17 AIR 1996 SC 1257.

18 AIR 1994 SC 1844.

19 Article 21 provides: "No person shall be deprived of his life or personal liberty except according to procedure established by law."

included, assistance in the commission of suicide and the attempting of suicide cannot be offences. They further argued that fundamental rights have both positive aspects and negative aspects and referred to other rights such as the freedom of speech which includes the freedom not to speak, and that this must similarly be true of the right to life. The court rejected this argument and held that the "'right to life' is a natural right embodied in Article 21 but suicide is an unnatural termination or extinction of life, and therefore, incompatible and inconsistent with the concept of 'right to life'".[20] Hence, it held that ss 306 and 309 did not violate that Article.

12 The court next considered the appellant's contention that s 309 violated Art 14 of the Constitution which provides for equality before the law. The appellants argued that s 309 did so because, in the absence of a definition of attempted suicide, the offence was made arbitrary. The appellants also argued that s 309 breached this Article in treating all attempts to commit suicide by the same measure without considering the circumstances in which attempts are made. The court rejected these arguments on the ground that suicide is capable of a broad definition and that the nature, gravity and extent of an attempt may be considered by a judge for sentencing purposes.[21]

13 Our Penal Code provisions are virtually identical to their counterparts in the Indian Penal Code, and Arts 9 and 12 of the Constitution of Singapore[22] correspond with Arts 21 and 14 of the Constitution of India respectively. Given the close similarities between the criminal and constitutional laws of Singapore and India as well as their shared legal history, the constitutional validity of ss 306 and 309 are most likely to be also upheld by our courts as the Supreme Court of India did in *Gian Kaur*. However, while the constitutional basis for the offences in question may be sound, it is the prerogative of Parliament to decide whether the offence should remain or be qualified in some way. The Supreme Court of India in *Gian Kaur* said as much when it noted that "[t]he desirability of bringing about a change [is] the function of the legislature".[23]

IV. The arguments for and against decriminalising physician-assisted suicide

14 The desirability or otherwise of PAS must be examined before any proposals for change to the current criminal law can be made. In

20 AIR 1996 SC 1257 at [22].
21 AIR 1996 SC 1257 at [30].
22 1999 Rev Ed.
23 AIR 1996 SC 1257 at [41].

this Part, the main arguments for decriminalising PAS are presented and evaluated, followed by those against taking this course.[24]

A. Arguments for decriminalisation

(1) Role of the criminal law

15 The overall role of the criminal law is the prevention of certain kinds of behaviour that society regards as either harmful or potentially harmful. The criminal law is applied by society as a defence against harms which injure the interests and values that are considered fundamental to its proper functioning. PAS is a harmless activity if the circumstances are such that death is seen as a benefit rather than a harm. This occurs where the prolongation of physical life results in harming the patient's mental, emotional or spiritual dimensions of his or her life, such that death serves as a liberation from unbearable suffering.[25]

16 Opponents of suicide argue that even the most rational act of suicide can produce real harms on the deceased's loved ones. For example, spouses may be left behind without their companions and children may be left to fend for themselves. However, cases of PAS are in a different category altogether as the person committing suicide is terminally-ill and facing imminent death. In these circumstances, the patient's voluntary self-killing is often done with the family's acceptance and consent.[26] Additionally, PAS can mean the "removal of social burdens, including the psychological, emotional, and/or financial burdens"[27] created by the terminally-ill patient.

(2) Autonomy

17 One popular argument in support of legalising PAS is patient autonomy – that terminally-ill patients should have some measure of autonomy to make choices concerning their own lives. Autonomy is a basic good, and thus, in the absence of harm to others, individuals should be allowed to do what they wish. In a secular society with a

24 For a fuller discussion of these arguments, see P Lewis, *Assisted Dying and Legal Change* (Oxford University Press, 2007) ch 2; N Gorsuch, *The Future of Assisted Suicide and Euthanasia* (Princeton University Press, 2006) chs 4, 6, 7 and 9; J Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation* (Cambridge University Press, 2002) chs 4, 5 and 6.

25 P Manga, "Euthanasia and Medically Assisted Suicide – The Case for Legalizing Physician Assisted Suicide" (2001) 20 Journal of Medicine and Law 451 at 456.

26 M Pabst Battin, *Ethical Issues in Suicide* (Prentice Hall, 1995) at p 211.

27 M Pabst Battin, *Ethical Issues in Suicide* (Prentice Hall, 1995) at p 209.

pluralism of moral convictions, individual freedom must be the pre-eminent value. As Penny Lewis has contended:[28]

> [A]lthough one may not be able to agree about what constitutes good life, or good death, one can agree to let each make its own choices, as long as those choices do not involve direct and significant violence against others.

18 On such a fundamental and personal matter as when and how to die, an individual should be allowed to make his or her own personal decision. If a patient thinks that continuing life in a state of unbearable suffering is a grave indignity and so inconsistent with his or her own assessment of what makes life worth living, he or she should be allowed to choose PAS. However, it is acknowledged that patient autonomy is not absolute and should not be translated into "death on demand". Several rigorous requirements must be met before the patient can avail himself or herself to PAS.

19 This argument has been subject to the criticism that it is not an exercise of the freedom of choice to be allowed to alienate one's freedom. Since suicide necessarily involves the complete renunciation of an individual's freedom, it is self-contradictory to exercise his or her autonomy in such a manner as to destroy the capacity for autonomy and its future exercise. While not denying the paradoxical nature of the argument based on patient autonomy, the authors maintain that "[m]aking someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny".[29]

(3) Consistency in the law

20 Currently, the Advance Medical Directive Act[30] enables a person of sound mind, who desires not to be subjected to the artificial prolongation of the dying process in the event of his or her suffering from a terminal illness, to make an AMD. If AMDs are allowed, why should we prohibit PAS? Opponents of PAS contend that the withdrawal or withholding of life-sustaining treatment allows death to take its natural course, whereas PAS is an artificial cause of death. This contention views AMD as being concerned with an omission and PAS with a positive act, with criminalisation occurring with respect to acts and not omissions. However, proponents of PAS would contend that there is no real distinction because both methods quicken death, and

28 P Lewis, *Assisted Dying and Legal Change* (Oxford University Press, 2007) at p 21.

29 R Dworkin, *Life's Dominion* (1993) at p 217 quoted in J Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation* (Cambridge University Press, 2002) at p 52.

30 Cap 4A, 1997 Rev Ed.

that the classification of the withdrawal or withholding of life-sustaining treatment as an omission is suspect.

21 The difficulty in drawing a distinction between the two methods is illustrated in the House of Lords case of *Airedale NHS Trust v Bland*[31] which involved Bland who was a patient in a persistent vegetative state. Medical opinion was unanimous that Bland's condition was irreversible and that there was no hope of any recovery or improvement in his condition. The issue before the court was whether all life-sustaining treatment could be lawfully discontinued given that Bland did not indicate, at any time before the accident, that this course of action should be taken. Although the judges accepted the submission that the doctors intended to kill Bland,[32] they ruled that the cessation of treatment was lawful by casting it as an omission rather than an active step. However, the classification of the cessation of treatment as an omission was questioned repeatedly in the judgments. For example, Lord Mustill expressed "acute unease" about resting his decision on the "morally and intellectually misshapen" distinction between acts and omissions, opining that "however much the terminologies may differ the ethical status of the two courses of action is for all relevant purposes indistinguishable".[33] In agreement, Lord Goff said that "it may be difficult to describe what the doctor actually does as an omission, for example where he takes some positive step to bring the life support to an end".[34] In spite of these reservations, the court eventually relied on the distinction to hold that it was lawful to kill Bland intentionally by omission.

22 It is submitted that the underlying reason for the ruling in *Airedale NHS Trust v Bland*[35] was because the judges recognised that Bland's life had fallen below a certain threshold and that it was not in his best interests to be kept alive. The court could not rely simply on this "best interest" reasoning because it would pave the way for legalising VAE and non-consensual euthanasia. Reverting to the comparison between AMDs and PAS, it is contended that legalising the former but not the latter on the basis of the act/omission distinction is tenuous. A careful consideration of AMDs and PAS shows that they share the same underlying rationale which is that people whose physical conditions have deteriorated to a certain level should be allowed to decide whether it is in their own best interest to be medically assisted to end their lives.

---

31 [1993] AC 789.

32 [1993] AC 789 at 881 where Lord Browne-Wilkinson said that "the whole purpose of stopping artificial feeding is to bring about the death of Anthony Bland".

33 [1993] AC 789 at 887.

34 [1993] AC 789 at 860. See also Lord Browne-Wilkinson: [1993] AC 789 at 885.

35 [1993] AC 789.

23 Another area of inconsistency in the current law concerns the doctrine of "double effect". This doctrine allows physicians to administer high doses of painkillers to patients with the knowledge that, besides minimising the patient's pain, there would be the inevitable side effect of hastening death. This is justified on the ground that the physician's primary aim is to relieve the patient's suffering and that it is merely a secondary effect that the patient dies as a result. However, the authors submit that it is hypocritical for the law to prohibit physicians from intentionally quickening a patient's death through PAS while permitting them to do so under the doctrine of double effect. When a physician knows that a side effect of the painkillers administered will certainly hasten the onset of death, this is tantamount to intention in the criminal law.[36] It may also be observed that the physician administering painkillers to the patient has a much greater causal connection with the patient's death compared to the one who only supplied the information or drug which the patient used to cause his or her own death. All told, it is not so obvious that a physician administering high doses of painkillers should be legally permitted to do so but not a physician supplying a fatal drug to a patient to administer himself or herself.

(4) Dying a dignified death

24 The legalisation of PAS will allow terminally-ill patients to die a dignified death. This argument is premised on the "Quality of Life" doctrine which places a premium on the worthwhileness of a patient's life. Where each or all of the aspects of a patient's life (which includes not only physical life but its mental, emotional and spiritual aspects) fall below a certain threshold, the continuation of such a life can be meaningless and immensely painful for the patient. There is much force in the view that:[37]

> [W]hat sort of a death is right for a particular person and gives the best meaning to that person's life, largely depends on how that life has been lived, and that the person who has lived it is in the best position to make that decision.

25 The Vitalist School would disagree, claiming that human life is an absolute moral value which requires it to be preserved at all costs, regardless of the pain, suffering or expense brought about by life-

36 See I Kennedy and A Grubb, *Medical Law* (Butterworths, 3rd Ed, 2000) at p 2114. This has been described by some criminal law commentators as "oblique" intention as opposed to "direct" intention which is purposeful in nature. The English Court of Appeal in *Re A (children) (conjoined twins)* [2000] 4 All ER 961 at 1012 acknowledged this contention.

37 R Dworkin, submission to the House of Lords, *Report on the Select Committee on Medical Ethics, Vol 1* (1993–1994) at p 23.

prolonging treatment.[38] Subscribing to this school of thought means that terminally-ill patients have no choice but to live on in an unacceptable manner until their natural death. The authors submit that this is too inhumane, cruel and insulting a process for the patient to have to experience who does not wish to have his or her life prolonged in this condition. Such a patient should have the right to request for PAS.

(5) Practical considerations

26 One practical reason favouring the decriminalisation of PAS is that patients can obtain the best assistance in terminating their own lives. Where patients do not have the means to obtain lethal medication legally, they could adopt inadequate or inappropriate methods to end their lives, resulting in undignified, violent and painful deaths. Failed suicide attempts may result in more serious complications of the patient's illness, and such deaths or attempted suicides could traumatise the patient's loved ones.

27 It is also realistic to assert that, even with their prohibition, acts of PAS are being conducted in secret. The lack of regulation of such cases is certainly not in the best interests of the patient or society in general. Legalisation of PAS and ensuing regulation of these acts is a vastly better option.

28 Another practical consideration supportive of PAS pertains to decisions by physicians justified by the doctrine of double effect to administer pain-relieving drugs. These decisions lack transparency and are much more difficult to monitor compared to a set of clear and strict legislative criteria which would have to be satisfied before a patient can request for PAS.

B. Arguments against decriminalisation

(1) Sanctity of life

29 Much objection against the legalisation of PAS stems from the sanctity of life argument which is largely based on religious beliefs. Followers of the Judeo-Christian faith regard PAS as morally wrong because "God gives life and only God can take it away".[39] This view stems

38 J Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation* (Cambridge University Press, 2002) at p 39. See also paras 29–33 of this article on "Sanctity of life".

39 The National Council of Singapore and the Catholic Archbishop of Singapore have publicly declared their opposition to the legalisation of VAE on this basis: see (*cont'd on the next page*)

from the ban stated in the Sixth Commandment. However, the true translation of that commandment is not a blanket "thou shalt not kill" but "thou shalt do no murder"[40] which clearly implies that killing of a human being may be permissible or even justifiable under certain conditions. If killing in self-defence, in times of war, or as a state-sanctioned punishment meted out to criminals does not qualify as murder, it is arguable that PAS (assistance rendered to patients to die, at their request and for their own benefit) should also not qualify as murder.[41] Furthermore, a predominant view held by Christians is that the most important commandment is to love. On this premise, PAS is permissible if it is done out of love for the patient, and not for the convenience and benefit of others.[42]

30 Islam is the most emphatic among the major religions practised in Singapore in regarding PAS to be morally wrong. It does so on the ground that all human life is sacred because it is given by Allah who alone decides on life and death.[43] Muslims believe that when an incurable illness continues for a long period, it should be viewed as an expression of Allah's will and that the patient is selected by Allah to undergo the test of suffering.[44] PAS is forbidden because it ignores Allah's ability to perform miracles and interferes with Allah's control over life and death. Furthermore, Islamic law holds physicians responsible for maintaining the process of life and not of dying.[45] A physician who assists in suicide would be utilising medicine for the opposite purpose for which it was created and this would be regarded as an offence against Allah.[46]

31 Buddhists, on the other hand, are not unanimous in their view of PAS. The most common position is that PAS is morally wrong

---

"Singapore debates where to draw the line for laws on assisted dying" *The Straits Times* (6 November 2008) at p A13.

40 See J Fletcher, *Morals and Medicine* (Princeton University Press, 1954) at p 196 noting that the Hebrew Decalogue "clearly means unlawful killing, treacherously, for private vendetta or gain".

41 G Williams, *The Sanctity of Life and the Criminal Law* (Knopf, 1957) at p 279.

42 G Williams, *The Sanctity of Life and the Criminal Law* (Knopf, 1957) at p 279.

43 V Rispler-Chaim, *Islamic Medical Ethics in the Twentieth Century* (EJ Brill, 1993) at p 95. The Islamic Religious Council of Singapore has publicly declared its opposition to VAE and PAS: see <www.asiaone.com/Health/News/Story/A1Story20081108-99167.html> (accessed 23 January 2010).

44 V Rispler-Chaim, *Islamic Medical Ethics in the Twentieth Century* (EJ Brill, 1993) at p 95. The Islamic Religious Council of Singapore has publicly declared its opposition to VAE and PAS: see <www.asiaone.com/Health/News/Story/A1Story20081108-99167.html> (accessed 23 January 2010).

45 V Rispler-Chaim, *Islamic Medical Ethics in the Twentieth Century* (EJ Brill, 1993) at p 97.

46 V Rispler-Chaim, *Islamic Medical Ethics in the Twentieth Century* (EJ Brill, 1993) at p 97.

because it demonstrates that a person's mind is in a bad state and that he or she has allowed physical suffering to cause mental suffering.[47] In accordance with this view, people should use the process of dying as an opportunity for reflection, and an enforced death would minimise this opportunity.[48] Also, PAS interferes with the working out of karma and alters the karmic balance resulting from the shortened life. However, another Buddhist view supports PAS for enabling a person to die in a good state of mind.[49] PAS enables a person to die sooner and in a calm and conscious manner which provides better learning during the death process as compared to a situation where a person is in a prolonged unconscious or pain-agitated state.

32 As for the Hindus, there are also two conflicting views concerning PAS.[50] The first is that the timing of the cycle of death and rebirth is disturbed when one assists in the ending of a life, even one filled with suffering. This is a bad thing to do, and those involved in the act will take on the remaining karma of the patient. The second view is that a person is performing a good deed and fulfilling his or her moral obligations when helping to end a painful life.[51]

33 Since there are opposing religious views about end-of-life decisions, the legalisation of PAS should not be influenced by religious considerations. More importantly, there are far too many Singapore residents who are not religious or who do not act in accordance with the beliefs of their own faiths. In a pluralistic society like Singapore's, differences in religious or philosophical beliefs and values should be respected to allow people to follow their own views about end-of-life matters. This is endorsed by Art 15 of our Constitution granting freedom of religion.

---

47 See *Buddhism, euthanasia and suicide online: BBC*, available at <http://www.bbc.co.uk/religion/religions/buddhism/buddhistethics/euthanasiasuicide.shtml> (accessed 23 January 2010). The Secretary-General of the Singapore Buddhist Federation has spoken out publicly against VAE: see L H Chieh & A Chong, "No 'Blessings' for euthanasia" *The Straits Times* (4 November 2008) at p B5.

48 P Harvey, *An Introduction to Buddhist Ethics* (Cambridge University Press, 2000) at p 296. See ch 7 for a more detailed discussion on Buddhist views towards suicide and euthanasia.

49 P Harvey, *An Introduction to Buddhist Ethics* (Cambridge University Press, 2000) at p 298.

50 See *Euthanasia and Suicide online: BBC*, available at <http://www.bbc.co.uk/religion/religions/hinduism/hinduethics/euthanasia.shtml> (accessed 23 January 2010).

51 This view is subscribed to by the Singapore Hindu Centre: see L H Chieh & A Chong, "No 'Blessings' for euthanasia" *The Straits Times* (4 November 2008) at p B5.

(2) Medical ethics

34 Upon completion of their medical degree, physicians take the Hippocratic Oath which directs them not to harm their patients but to treat them. The portion of the Oath relevant to this discussion reads:

> I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrongdoing. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course.

35 Consequently, opponents of PAS argue that physicians would violate the Hippocratic Oath if they accede to a request for PAS.

36 It can, however, be argued that administering painkillers to patients is akin to administering poison which is expressly forbidden by the Oath.[52] Moreover, in the original version of the Oath, physicians were prohibited from performing surgeries or taking fees for imparting medical knowledge. If these acts are permitted now, it is difficult to appreciate why PAS should be prohibited, especially given the fact that the patient is incurable.[53] Furthermore, it would be ethically and professionally inconsistent for physicians to bring a patient to a point of painful and meaningless existence with no hope of cure or relief from suffering, and then refuse such a patient's request for PAS just because assisting in the patient's death violates the Oath. Physicians should not regard themselves solely as healers with death signifying medical failure; instead they should consider their role as encompassing three goals: "healing, promoting health and helping patients achieve a peaceful and dignified death".[54] A modern version of the Oath, formulated by Louis Lasagna and used in many medical schools today, takes a more nuanced approach when it states:

> I will apply, for the benefit of the sick, all measures that are required, avoiding those twin traps of overtreatment and therapeutic nihilism …
>
> Most especially, I must tread with care in matters of life and death. If it is given to me to save a life; all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty.

52 See discussion on the doctrine of "double effect" at para 23 of this article.

53 M Pabst Battin, *Ethical Issues in Suicide* (Prentice Hall, 1995) at p 206.

54 P Manga, "Euthanasia and Medically Assisted Suicide – The Case for Legalizing Physician Assisted Suicide" (2001) 20 Journal of Medicine and Law 451 at 455.

(3) Worrying effects of legalisation

37 There are grave concerns that the legalisation of PAS would lead to a slide down a slippery slope from PAS to something which is more widely opposed such as VAE or non-consensual euthanasia. Concerns have also been voiced that undesirable changes in social attitudes towards death, illness, old age and the medical profession would be brought about in the long run. For example, the elderly and the disabled will be encouraged to end their lives so that they will not become a burden to their families and to society. Lives will become dispensable thereby making it easier to kill people who are comatose, retarded or suffering from crippling diseases, and this may further degenerate to condoning the killing of the poor or socially undesirable.[55]

38 However, slippery slope arguments such as these are largely speculative. These concerns will not become reality where strict regulations and safeguards are put in place and actively enforced. It is also important to emphasise that legislation is the prerogative of Parliament. Alterations to the current law allowing other forms of medical killing is unlikely to be done without serious deliberation and thorough public debate over the ethics and practicalities of any proposed alteration.

39 Another concern is that vulnerable people may be harmed by PAS on account of their failure to make a free, fully-informed and rational choice. A patient's choice could be improperly influenced by several factors such as depression and their feeling of being a burden to others. Patients could also be unduly influenced in their decision-making by unscrupulous family members or associates. However, these concerns can be addressed by the imposition of safeguards such as the compulsory psychiatric examination of the patient and reliance on independent witnesses to ensure that the patient's request was truly informed and voluntary.

40 There is also the view that "autonomous, rational suicide does not exist, and that a desire for death is a sign of mental illness and not of rational choice".[56] In reply, it is asserted that:[57]

> [I]t is not idiosyncratic, selfish, or indicative of a psychiatric disorder for people with an incurable illness to want some control over how they die. The idea of a noble, dignified death, with a meaning that is

55 T Cipriani, "Give Me Liberty and Give Me Death" (1995–1996) 3 Journal of Law and Medicine 177 at 186.

56 P Lewis, *Assisted Dying and Legal Change* (Oxford University Press, 2007) at p 24.

57 T Quill, S Tolle & G Annas, "Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide" (1992) 327(19) New England Journal of Medicine 1380 at 1380.

deeply personal and unique, is exalted in great literature, poetry, art and music.

41 Having evaluated the primary arguments for and against the decriminalisation of PAS, it is contended that the benefits far outweigh the harms in allowing terminally-ill patients to be given the option of choosing PAS. This position has been arrived at by viewing the various arguments primarily from the perspective of the patient and by placing a premium on patient-autonomy.

V. Models for legalising physician-assisted suicide

42 In this Part, the authors present and evaluate the laws and regulatory structures of three different jurisdictions which have legalised PAS, namely, the Netherlands, Oregon and the Northern Territory of Australia. All three models enable patients to request for assisted dying where certain conditions are met, and regulate physician behaviour. In line with the preceding analysis of the arguments for and against decriminalising PAS, a patient-centred approach will generally be taken when evaluating the specific rules and regulations of these models. The primary purpose of this comparative study will be to draw out the best features of these models with a view to drafting appropriate PAS legislation for Singapore.

A. Introducing the models

(1) The Netherlands

43 The Dutch law has been selected for study because the Netherlands was the first country in the world to legalise both PAS and VAE. PAS is made an offence by virtue of Arts 293[58] and 294[59] of the Dutch Penal Code. However, in 1984, the Dutch Supreme Court held that a physician who ends the life of a patient may in certain circumstances successfully invoke the defence of necessity.[60] Following that decision, there was much development[61] in this area which eventually led to the enactment of the Termination of Life on Request

58 Before 2002, Art 293 of the Dutch Penal Code provided that a "person who takes the life of another person at that other person's express and earnest request" is guilty of a serious offence.

59 Before 2002, Art 294 of the Dutch Penal Code provided that "a person who intentionally incites another to commit suicide, assists in the suicide of another, or provides for that other person the means to commit suicide" is guilty of a serious offence. Suicide itself is not an offence.

60 See the case of *Schoonheim, Netherlandse Jurisprudentie* 1985, no 106.

61 See generally J Griffiths, H Weyers & M Adams, *Euthanasia and Law in Europe* (Hart Publishing 2008) Pt 1.

and Assisted Suicide (Review Procedures) Act ("Law of 2002").[62] This legislation codified the practice of PAS and VAE in the Netherlands since 1984. Under the Law of 2002, a physician who terminates a life on request or assists with a suicide has, in order to be exempted from criminal liability, to fulfil the due care criteria[63] prescribed by the legislation and report the cause of death to the municipal coroner.

(2) Oregon

44 The experience of this jurisdiction is significant for being the first state in the US to legalise PAS. Additionally, this model continues to criminalise VAE,[64] an arrangement which this article supports. The Oregon Death with Dignity Act ("DWDA") was a citizens' initiative authorising PAS. It was passed in 1994 as Ballot Measure 16, with 51% of the voters in favour. After several legal challenges,[65] the DWDA was finally approved in November 1997. The DWDA allows physicians to prescribe lethal drugs to a patient who has requested for them under stringent conditions which appear to be working reasonably well in practice.[66] In particular, they have prevented a stampede of requests, feared by some critics of the Act, from eventuating.

(3) The Northern Territory

45 The experience of this Australian jurisdiction, though short lived, has been chosen for study because it has featured prominently in debates over the decriminalisation of VAE and PAS not only in Australia but wherever the debate has occurred. The Rights of the Terminally Ill Act 1995 (NT) ("ROTTI"), which legalised both PAS and VAE, gave a terminally-ill person the right to request assistance from physicians to voluntarily terminate his or her life in a humane manner, without legal impediment to the physician.

46 The ROTTI was repealed by the Euthanasia Laws Act (Cth) 1997.[67] The repeal originated as a private member's Bill before the

62 Termination of Life on Request and Assisted Suicide (Review Procedures) Act entered into force on 1 April 2002. An English translation of the Act is available online at < http://www.healthlaw.nl/index2.html > (accessed 23 January 2010).

63 Termination of Life on Request and Assisted Suicide (Review Procedures) Act Art 2.

64 Oregon Death with Dignity Act 127.880 §3.14 which expressly prohibits the ending of a patient's life "by lethal injection, mercy killing or active euthanasia".

65 The implementation of the Oregon Death with Dignity Act was delayed pending a court challenge to its constitutionality.

66 G Tulloch, *Euthanasia – Choice and Death* (Edinburgh University Press, 2005) at p 66.

67 Since the Northern Territory falls within the Federal jurisdiction of the Commonwealth of Australia, the Federal Parliament can enact laws for it or rescind its laws.

Federal Parliament, which many voted in its favour due to their personal religious beliefs.[68] There has since been a move to reinstate the ROTTI by repealing the Euthanasia Laws Act.[69]

B. The principal features of the models

47 The main features of these three models will now be presented, compared and evaluated in the course of which the Singapore position or what is felt most suited for Singapore will be advocated.

(1) Age

48 The three models require the patient to have been 18 years of age or older.[70] In Singapore, the age of the patient is likely to be set at 21 years instead. In *Bank of India v Rai Bahadur Singh*, the Singapore Court of Appeal held that to be the age of majority in relation to the entering of valid commercial transactions.[71] Also, for the purposes of the Advance Medical Directive Act[72] (an Act closely related to the current discussion), a patient must have attained the age of 21 years in order to make a directive.

(2) Residency

49 Of the three models examined, only the DWDA imposes a residential requirement. Factors which can satisfy this condition include possession of an Oregon driver licence, registration to vote in Oregon, evidence that the person owns or leases property in Oregon or filing of an Oregon tax return for the most recent tax year.[73] However, the DWDA does not prescribe a minimum period of residence.

---

68 See S Yeo, "Right to Die" (2003) 28 Alternative Law Journal 89 at 91 who opined that "[i]t is highly regrettable that the personal religious beliefs of a select few wielding political power could overturn the view of a sizable majority of the Australian community favouring the legalizing of euthanasia in limited circumstance".

69 See the Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008.

70 The Termination of Life on Request and Assisted Suicide (Review Procedures) Act also contains provisions concerning minor patients.

71 [1994] 1 SLR(R) 89. The Court of Appeal was concerned with the issue of whether two Indian youths aged above 18 but below 21 years, who made financial commitments to a bank, were competent to enter into commercial agreements with banks. The Court of Appeal affirmed the High Court's decision that as there were no statutory provisions fixing the age of a person who can validly enter into a commercial transaction, the default age of majority would remain as that stipulated at common law, which was 21 years.

72 Cap 4A, 1997 Rev Ed.

73 Oregon Death with Dignity Act 127.860 §3.10.

50 It is submitted that, for Singapore, strict residential requirements should be set out, including a minimum period of residence. Residential requirements can act as an effective safeguard against "death tourism" where foreigners visit the country solely for the purposes of PAS. The residential requirements imposed by the Income Tax Act[74] for the purposes of income tax assessment could be adapted for the proposed PAS legislation.

(3) Health

51 All three models studied provide some requirements pertaining to the patient's health or condition. The due care criteria under the Dutch Law of 2002 stipulate that the patient's suffering must be "lasting and unbearable" and without any prospect of improvement. This stipulation has been criticised for being "elastic and open to varying interpretations"[75] which has resulted in the regional review committees[76] having to emphasise that the suffering must be understandable to a normal doctor and also the committee. The Law of 2002 does not require the patient to be terminally ill to the extent of dying within a few months.

52 The DWDA provides that the patient must be "suffering from a terminal disease"[77] which is defined as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months".[78] The requirement that the patient must be terminally ill to the extent of dying within a specified period seeks to clarify the sort of cases that will be covered by the legislation. Unfortunately, this definition is unclear as to whether it requires the disease to produce death within six months *with or without treatment*. In this regard, the ROTTI is clearer in defining "terminal illness" as an illness which "in reasonable medical judgment will, in the normal course, *without the application of extraordinary measures or*

74 Cap 134, 2008 Rev Ed s 2 defines "resident in Singapore" as follows: "(a) in relation to an individual, means a person who, in the year preceding the year of assessment, resides in Singapore except for such temporary absences therefrom as may be reasonable and not inconsistent with a claim by such person to be resident in Singapore, and includes a person who is physically present or who exercises an employment (other than as a director of a company) in Singapore for 183 days or more during the year preceding the year of assessment; and (b) in relation to a company or body of persons, means a company or body of persons the control and management of whose business is exercised in Singapore."

75 House of Lords, *Report of the Select Committee on Medical Ethics*, Vol 1 (1993–1994, HMSO) at p 67.

76 These committees are responsible for ensuring that the due care criteria of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act have been met by the attending physician: see para 66 of this article.

77 Oregon Death with Dignity Act 127.805 §2.01.

78 Oregon Death with Dignity Act 127.800 §1.01(12).

treatment unacceptable to the patient, result in the death of the patient" [emphasis added].[79] However, there is no requirement that the patient must be terminally ill to the extent of dying within the next few months, and the term "extraordinary measures" is vague and left undefined. Aside from the requirement that the patient must be terminally ill, the ROTTI requires the patient to be "experiencing pain, suffering and/or distress to an extent unacceptable to the patient".[80]

53 It is submitted that an unambiguous and restrictive stipulation of the patient's health is needed to limit the availability of PAS in Singapore. Besides providing for only the most deserving of cases, tight health criteria for eligibility to request for PAS would help allay fears based on the "slippery slope" argument. It is proposed that for a patient to be eligible for PAS, he or she has to be suffering from a terminal illness which, according to reasonable medical judgment, is likely to result in death within six months without extraordinary life-sustaining treatment. Additionally, the illness must be associated with "severe, unrelenting and intolerable suffering"[81] which may be physical, mental or emotional in nature. The definitions of "terminal illness" and "extraordinary life-sustaining treatment" can be adopted from s 2 of the Advance Medical Directive Act.[82]

(4) Palliative care

54 Of the three models examined, only the ROTTI provides for a requirement of palliative care before PAS can be given. The ROTTI prohibits physicians from providing assistance if there are palliative care options reasonably available to the patient to alleviate his or her suffering to levels acceptable to the patient.[83] The provision of palliative care is needed to ensure that the patient's request for PAS is not the result of inadequate comfort care. Accordingly, palliative care should be provided to patients before receiving their requests for PAS.[84] The authors agree, and submit that the proposed Singapore legislation should require patients to receive palliative care, only after which they can decide whether to request for PAS on the ground that palliative care was not a reasonable solution for them. Adhering to patient-autonomy, it is for the patient and not some other person, such as his or her physician, to make this decision.

---

79 Rights of the Terminally Ill Act 1995 (NT) s 3.
80 Rights of the Terminally Ill Act 1995 (NT) s 4.
81 T Quill, *Death and Dignity* (WW Norton, 1993) at p 162.
82 Cap 4A, 1997 Rev Ed.
83 Rights of the Terminally Ill Act 1995 (NT) s 8.
84 R Cohen-Almagor & M Hartman, "The Oregon Death with Dignity Act: Review and Proposals for Improvement" (2001) 27 Journal of Legislation 269.

(5) Form of request and waiting period

55 The Dutch due care criteria require the physician to be satisfied that the request by the patient was voluntary and well considered. However, it fails to elaborate upon the form in which the request must have been made, unlike both the DWDA and ROTTI.

56 The DWDA requires the patient to have made both an oral request and a written request, and to have reiterated the oral request to the attending physician no less than 15 days after the initial request.[85] However, the 15-day wait is arguably too long for a terminally-ill patient. It has been reported that 20% of patients who requested PAS died during this waiting period.[86] The nine-day waiting period provided for in the ROTTI seems more appropriate. Both the DWDA and ROTTI also provide that no less than 48 hours shall have elapsed between the written request and the writing of the prescription.[87] This will allow time for the patient to decide against going ahead with committing suicide.

57 Such repeated requests by the patient both verbally and in writing enable the physician to be convinced of the patient's desire to die and to ensure that the request is enduring. Also, an adequate waiting period between the making of the request and the physician's rendering of assistance is critical in allowing the patient to consider the matter carefully. It also allows the physician to evaluate the patient's rationality and to confirm that all alternative treatment options, including palliative care, have been adequately explored.

(6) Rescission of request

58 Both the DWDA and ROTTI provide that the patient may rescind any request for PAS at any time and in any manner.[88] The DWDA additionally requires the attending physician to inform the patient of the right of rescission, and to offer the patient an opportunity to rescind at the end of the 15-day waiting period.[89] The stance taken by the DWDA is attractive for putting in place procedures which help ensure that it is for the patients alone to decide whether or not to proceed with PAS, and that every opportunity is afforded to them to change their minds.

---

85 Oregon Death with Dignity Act 127.840 §3.06.

86 A Rothschild, "Oregon: Does physician-assisted suicide work?" (2004/2005) 12 Journal of Law and Medicine 217 at 222.

87 See Oregon Death with Dignity Act 127.850 §3.08 and Rights of the Terminally Ill Act 1995 (NT) s 7(1)(n), respectively.

88 See Oregon Death with Dignity Act 127.845 §3.07 and Rights of the Terminally Ill Act 1995 (NT) s 10, respectively.

89 Oregon Death with Dignity Act 127.815 §3.01(h).

(7) Witnesses

59 The ROTTI provides that the certificate of request must be signed in the presence of the patient and the first doctor, by another doctor who could be the second doctor involved in the process of ensuring that the patient's request was well informed and voluntary.[90] The DWDA provides that the signing of the request form shall be witnessed by at least two people who, in the presence of the patient, attest that to the best of their knowledge and belief, the patient is capable, acting voluntarily, and is not being coerced to sign the request.[91] At least one of the witnesses must not be related to the patient or entitled to benefit from the patient's estate, or be an owner, operator or employee of a healthcare facility where the patient is receiving treatment or is a resident. The attending physician cannot be a witness. The arrangement under the DWDA is attractive for involving lay people instead of physicians to witness the patient's written request for PAS and to attest to his or her voluntariness in doing so. This constitutes a further safeguard against physicians unduly influencing their patients to opt for PAS. As an added precaution against undue influence, any member of the patient's family and anyone who stands to benefit financially from the patient's death, would be prohibited from serving as a witness.

(8) Physicians and their duties

60 The Dutch due care criteria provide that the physician must have consulted at least one other independent physician whose role is to act as a check on the attending physician. However, "independent physician" is left undefined.

61 Similarly, the DWDA requires the involvement of two physicians – the attending physician[92] and the consulting physician.[93] The attending physician has to first determine whether the patient is terminally ill, is capable of making an informed decision and has done so, and has made the request for PAS voluntarily. The consulting physician is defined as a physician "who is qualified by specialty or experience to make a professional diagnosis regarding the patient's

90 Rights of the Terminally Ill Act 1995 (NT) s 7(1)(k). In all, three doctors are involved: see para 62 of this article.

91 Oregon Death with Dignity Act 127.805 §2.02.

92 See Oregon Death with Dignity Act 127.815 §3.01 for the attending physician's responsibilities.

93 See Oregon Death with Dignity Act 127.820 §3.02 for the consulting physician's responsibilities. The consulting physician's role is to confirm, in writing, the attending physician's diagnosis of the patient's terminal illness and that the patient is capable, is acting voluntarily and has made an informed decision.

disease".[94] However, this definition is very broad and most medical practitioners would qualify. This could lead patients to "fish around" for a consulting physician who is supportive of PAS. There is also no requirement that the consulting physician is independent of the attending physician. If either physician thinks that a patient may be suffering from "a psychiatric or psychological disorder, or depression causing impaired judgment", the physician shall refer the patient for counselling.[95] No lethal prescription may be written until the person performing the counselling determines that the patient is not so suffering. While there is some form of protection of the patient by the physician's referral to a counsellor, there is no requirement that the counsellor is trained in psychology.

62 The ROTTI requires that the opinions of three doctors be obtained as to whether the patient's request for PAS was well informed and voluntary. Besides the first doctor, the Act requires the patient to be examined by two other independent doctors, one a qualified psychiatrist and the other a medical practitioner who holds the prescribed qualification or has the prescribed experience in the treatment of the terminal illness from which the patient was suffering.

63 It is submitted that the involvement of an experienced consultant physician and a psychiatrist is crucial in ensuring the voluntariness and rationality of the patient's request, the accuracy of the attending physician's diagnosis and prognosis, and the full exploration of other treatment alternatives. It is vital for the consulting physician to have personally interviewed and examined the patient, and to be independent of the attending physician. It is also crucial for there to be a psychiatric evaluation of the patient to ensure that he or she is not suffering from depression or other mental illness which can distort his or her judgment. Additionally, the authors submit that the attending physician should be legally prohibited from persuading the patient to opt for PAS, and that the consulting physician should check to ensure that the attending physician has not done so.

(9) Family notification

64 Under the DWDA, the attending physician is required to recommend to the patient that he or she notify the next of kin of his or her decision to request for PAS.[96] However, a patient who refuses to or is unable to make such a notification can still go ahead with PAS. Similarly, ROTTI requires the patient's doctor to be satisfied that the patient had

94 Oregon Death with Dignity Act 127.800 §1.01(4).
95 Oregon Death with Dignity Act 127.825 §3.03.
96 Oregon Death with Dignity Act 127.835 §3.05.

considered the possible implications of the decision for his or her family.[97]

65 There is much to be said for requiring the attending physician to strongly recommend their patients to consider the possible impact of their decision for PAS on their family and others having close and affectionate ties, and to notify or consult them. Such an important decision should not be kept from these people, especially the patient's family because they are likely to be affected most by it. This is particularly important in Singapore where the family is seen as the building block of our society and nation. However, in line with the view that the patient's autonomy is paramount, control over whom to notify or consult, if at all, should be left to the patient to decide.

(10) Documentation and reporting

66 The Dutch due care criteria require physicians to notify the municipal pathologist of any act of PAS performed by them. The physician must complete a prescribed form and supplement it with a reasoned report with respect to observing the requirements of due care. The Law of 2002 also provides for the establishment of regional review committees for the termination of life on request and assisted suicide.[98] The committee assesses whether a case of PAS is in accordance with the due care criteria.[99] The committee may request the physician to supplement his or her report verbally or in writing. Where a committee is of the opinion that the physician did not act in accordance with the due care requirements, the case must be brought to the attention of the Public Prosecution Service which has the power to launch a criminal investigation.

67 The DWDA similarly requires the attending physician to satisfy certain requirements relating to documentation.[100] He or she must document in the patient's medical records all oral and written requests, the attending and consultant physicians' diagnoses, prognoses and determinations that the patient is capable, acting voluntarily and has made an informed decision. Also to be documented are reports of any counselling sessions, records of the offer made by the physician for the patient to rescind his or her request, and a note by the attending physician indicating that all steps required by the DWDA have been carried out and the steps taken to carry out the request, including a

97 Rights of the Terminally Ill Act 1995 (NT) s 7(1)(g).

98 Termination of Life on Request and Assisted Suicide (Review Procedures) Act s 3. Each committee comprises an uneven number of members, including one legal specialist who is also the chair, one physician and one expert on ethical or philosophical issues.

99 Termination of Life on Request and Assisted Suicide (Review Procedures) Act s 8.

100 Oregon Death with Dignity Act 127.855 §3.09.

description of the medication prescribed. The attending physician is also required to file a brief report with the Oregon Health Division. However, unlike the Netherlands where each case is investigated by a review committee, the DWDA merely provides for an administrative process of documentation and reporting.

68 The ROTTI requires the doctor who performed the PAS to send certain documentation to the coroner. However, the Act does not empower the coroner to investigate cases of PAS. In the absence of evidence indicating a failure to comply with the Act, the coroner's role is limited to filing a report with the Attorney-General stating the number of assisted deaths notified in that year. Given that the relevant documentation was prepared by the doctors involved, it is unlikely that any evidence of non-compliance would emerge from those documents.

69 The authors submit that Singapore should require attending physicians to compile and keep medical records similar to those of DWDA. We should also adopt the Dutch safeguard of having a committee to review and investigate each case. To ensure compliance, attending physicians who breach their duties should be held liable for an offence.

(11) Physician's presence

70 Neither the Law of 2002 nor the DWDA requires the physician's physical presence when the patient self-administers the lethal medication. This fails to take into account the fact that the patient may need medical assistance or psychological reassurance when the medication is taken.[101] Moreover, the physician's absence at this critical time could create evidential problems with regard to reporting procedures since he or she can only provide hearsay evidence of those who were present.[102] In this regard, the ROTTI is to be preferred for requiring the physician to be present until the death of the patient.[103] As an added measure, the authors propose requiring the consulting physician to also be present to witness the occasion and to provide advice and support to the attending physician. Both physicians should be made to submit separate written reports of what they each witnessed and did on that occasion.

101 A Rothschild, "Oregon: Does physician-assisted suicide work?" (2004/2005) 12 Journal of Law and Medicine 217 at 222.

102 A Rothschild, "Oregon: Does physician-assisted suicide work?" (2004/2005) 12 Journal of Law and Medicine 217 at 222.

103 Rights of the Terminally Ill Act 1995 (NT) s 7(1)(p).

(12) Respecting the medical profession

71 Under both the DWDA and ROTTI, if the physician is unwilling or unable to carry out his or her patient's request for PAS, the physician may transfer the case to another physician.[104] Although the Law of 2002 does not explicitly provide for the same, it is clear that no doctor has any obligation to accede to a request for assisted suicide under the Act.[105] This is a sound position since no physician should be compelled to assist in a patient's suicide if it violates his or her personal principles and opinions concerning PAS. Furthermore, education, training and counselling should be provided to physicians and all other medical personnel involved in PAS to help them cope with the emotional stresses which assisting a patient to commit suicide might cause.

(13) Immunity

72 The DWDA provides that no person acting "in good faith" shall be subject to liability for performing PAS.[106] The test of "in good faith" is met so long as the physician genuinely believed that he or she had complied with the various regulations governing PAS. This means that a physician who acted negligently in the process of assisting suicide will not be liable so long as he or she had acted in good faith. This subjective "good faith" standard has been criticised for being far less strict than the objective "reasonable standard of care" which physicians are required to meet for other forms of medical treatment.[107] The authors submit that it is inconsistent for the law to lower the standard of care expected of physicians in respect of PAS, especially given the irredeemable outcome of such assistance. In this regard, ROTTI and the Law of 2002 are to be preferred for requiring the physician to have acted with due care.[108] Adopting this requirement will result in physicians involved with PAS being held to the same reasonable standard of care expected of physicians when performing their professional duties.[109]

---

104 See Oregon Death with Dignity Act 127.885 §4.01(4) and Rights of the Terminally Ill Act 1995 (NT) ss 5 and 20(4) respectively.

105 This is because the legal regulation of euthanasia in the Netherlands takes the form of a justification which is available only to doctors and it follows that patients have no right to euthanasia even if the patient meets all the legal requirements: see J Griffiths, H Weyers & M Adams, *Euthanasia and Law in Europe* (Hart Publishing 2008) at p 107.

106 See Oregon Death with Dignity Act 127.885 §4.01 and Rights of the Terminally Ill Act 1995 (NT) s 20 respectively.

107 International Task Force on Euthanasia and Assisted Suicide, *Seven Years of Assisted Suicide in Oregon* at <http://www.internationaltaskforce.org/orrpt7.htm> (accessed 23 January 2010).

108 Rights of the Terminally Ill Act 1995 (NT) s 20; Termination of Life on Request and Assisted Suicide (Review Procedures) Act s 2(1)(f).

109 Under Singapore law, the standard of medical care is encapsulated in the test pronounced in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582

(*cont'd on the next page*)

VI. Conclusion

73 Drawing on the above critical evaluation of the laws and regulatory procedures of the Netherlands, Oregon and the Northern Territory, the authors have appended a statute for possible implementation in Singapore.

74 The rapidly ageing population of Singapore calls for much more to be done than the provision of AMDs and improved palliative care by the Government with regard to end-of-life issues. It is time for the criminal law to be revised to help terminally-ill patients who are experiencing unbearable physical, mental or emotional pain with no prospect of improvement, to be medically assisted to end their suffering and to die with dignity. This could be achieved by enacting the Physician Assisted Act proposed in this article.

75 The authors wish to reiterate that their proposal to decriminalise PAS should be considered in isolation from the question of whether or not VAE should also be legalised. While that may be regarded by some to be the next step after PAS has been legalised, it does not at all follow that this must be taken. The patient's terminating of his or her own life distinguishes it sufficiently from VAE where it is the physician who terminates the patient's life. Accordingly, lumping VAE with PAS is apt to muddy the case for legalising PAS and should be strenuously avoided. The Oregon experience, where only PAS has been legalised, is a prime example of a jurisdiction which has successfully done this.

76 It is acknowledged that it might be difficult to formulate directions or guidelines on the extent of assistance the physicians involved with PAS can give while still maintaining the patient's control over his or her own taking of the lethal medication.[110] Specifically, how can the line between assistance and active euthanasia be drawn? For example, is putting a cup with lethal medication to the patient's lips but with the patient swallowing unassisted, within the boundaries of PAS?[111] And what can the physicians do if the patient took the medication but did not die within a relatively short period of time? It is submitted that such difficulties are not insurmountable and that it would be feasible for a specially constituted body, similar to the review committee suggested

which requires physicians to act in accordance with a standard of practice recognised as proper by a competent body of professional medical opinion. The *Bolam* test has been accepted by the Singapore Court of Appeal in *Khoo James v Gunapathy d/o Muniandy* [2002] 2 SLR(R) 1024.

110 A Rothschild, "Oregon: Does physician-assisted suicide work?" (2004/2005) 12 Journal of Law and Medicine 217 at 222.

111 A Rothschild, "Oregon: Does physician-assisted suicide work?" (2004/2005) 12 Journal of Law and Medicine 217 at 222.

in this article, to devise a workable policy and accompanying set of guidelines. Also, the requirement that the attending and consulting physicians submit separate reports to the review committee describing the process of the patient taking the medication until his or her death and what the physicians did, would provide opportunities for the committee to further develop or fine-tune these guidelines.

APPENDIX

A Statute for Legalising and Regulating Physician-assisted Suicide

Physician Assisted Suicide Act

An Act to provide for the right of a terminally-ill person to request a medical practitioner to assist that person to voluntarily terminate his or her own life in a humane and dignified manner; and to allow such assistance to be given in certain circumstances without legal impediment to the medical practitioner rendering the assistance; and for matters connected therewith.

Short Title

1. This Act may be cited as the Physician Assisted Suicide Act.

Interpretation

2. In this Act, unless the context otherwise requires –

"attending medical practitioner" means the medical practitioner who has primary responsibility for the care of the patient and the treatment of the patient's terminal illness;

"consulting medical practitioner" means a medical practitioner who –

(a) possesses the medical qualifications in the treatment of the terminal illness from which the patient is suffering; and

(b) is not a relative or employee of, or member of the same medical practice as the attending medical practitioner;

"Director" means the Director of Medical Services;

"extraordinary life-sustaining treatment" means any medical procedure or measure which, when administered to a terminally-ill patient, will only prolong the process of dying when death is imminent, but excludes palliative care;

"informed decision" means a decision by a patient to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending medical practitioner of –

(a) his or her medical diagnosis;

(b) his or her prognosis;

(c) the potential risks associated with taking the medication to be prescribed; and

(d) the probable result of taking the medication to be prescribed;

"medical practitioner" means a person who is registered, or deemed to be registered, as a medical practitioner under the Medical Registration Act (Cap. 174);

"patient" means any person of sound mind who has attained the age of 21 years and who has made or desires to make a request in accordance with this Act;

"psychiatrist" means any registered medical practitioner who has experience in the diagnosis and treatment of mental disorders and holds a recognised diploma in psychiatry or other equivalent qualification approved by the Director of Medical Services;

"request" means a request made under section 3;

"resident in Singapore" means a person who resides in Singapore except for such temporary absences as may be reasonable and not inconsistent with a claim by such person to be resident in Singapore, and includes a person who is physically present in Singapore for at least 183 days before the request is made;

"Review Committee" means a committee established under section 12;

"terminal illness" means an incurable and irreversible condition caused by injury or disease from which there is no reasonable prospect of a temporary or permanent recovery and would, within reasonable medical judgment, produce death within six months without the application of extraordinary life-sustaining treatment.

Power to make request

3.—(1) A person of sound mind who –

(a) is a resident of Singapore;

(b) has attained the age of 21 years;

(c) has been determined by the attending medical practitioner and consulting medical practitioner to be suffering from a terminal illness and that his or her condition is associated with severe, unrelenting and intolerable physical, mental or emotional suffering;

(d) has received palliative care that is reasonably available;

(e) holds the conviction that there is no other reasonable solution for the situation he or she is in;

(f) has been certified by a psychiatrist that he or she is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment; and

(g) who has voluntarily expressed his or her wish to die,

may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in the prescribed form.

(2) In order to receive a prescription for medication to end his or her life in a humane and dignified manner, a patient shall have made an oral and written request, and reiterate the oral request to his or her attending medical practitioner no less than nine (9) days after making the initial oral request. At the time the patient makes his or her second oral request, the attending medical practitioner shall offer the patient an opportunity to rescind the request.

Written request

4.—(1) A written request shall be signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief, the patient is making the request voluntarily, without inducement or compulsion and has been informed of the nature and consequences of making the request.

(2) Any person who –

(a) is a relative of the patient by blood, marriage or adoption;

(b) is a beneficiary under the will or any policy of insurance of the patient;

(c) would be entitled to an interest in the estate of the patient on the death intestate of the patient; or

(d) would be entitled to an interest in the moneys of the patient held in the Central Provident Fund or other provident fund on the death of that patient,

shall not be a witness under subsection (1).

Right to rescind request

5. A patient may rescind his or her request at any time and in any manner without regard to his or her mental state.

Duty of attending medical practitioner

6. The attending medical practitioner shall –

(a) ensure that the patient is a resident of Singapore and has attained the age of 21 years;

(b) make the initial determination of whether a patient has a terminal illness, is of sound mind, and has made the request voluntarily;

(c) determine whether the patient's condition is associated with severe, unrelenting and intolerable physical, mental or emotional suffering;

(d) confirm that the patient holds the conviction that there is no other reasonable solution for the situation he or she is in after receiving palliative care as provided for in section 9;

(e) ensure that the patient is making an informed decision;

(f) not in any way persuade the patient to make the request;

(g) refer the patient to a consulting medical practitioner for medical confirmation of the diagnosis of terminal illness, for a determination that the patient is of sound mind, and has made the request voluntarily;

(h) refer the patient to a psychiatrist;

(i) strongly encourage the patient to consult his or her family and others having close and affectionate ties with the patient;

(j) inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the 9-day waiting period pursuant to section 3(2);

(k) be present when the patient takes the prescribed medication and shall remain present until the death of the patient, and report in writing what he or she witnessed and did on that occasion; and

(l) fulfil the documentation and reporting requirements pursuant to section 11.

Duty of consulting medical practitioner

7. A consulting medical practitioner shall –

(a) examine the patient and his or her relevant medical records and confirm, in writing, the requirements set out in section 6(*a*) to (*f*) above have been met; and

(b) be present when the patient takes the prescribed medication and shall remain present until the death of the patient, and report in writing what he or she witnessed and did on that occasion.

Duty of psychiatrist

8.—(1) A psychiatrist must confirm, in writing, that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

(2) No medication to end a patient's life shall be prescribed until a psychiatrist so verifies.

Palliative care

9.—(1) The attending medical practitioner shall not prescribe medication to end a patient's life in a humane and dignified manner if in his or her opinion, and after considering the advice of the consulting medical practitioner, there are palliative care options reasonably available to the patient to alleviate the patient's suffering to levels acceptable to the patient.

(2) The patient shall be required to receive palliative care if there are such options reasonably available to the patient. If the palliative care ceases to alleviate the patient's suffering to levels acceptable to the patient, the medical practitioner may prescribe medication to end the patient's life in a humane and dignified manner if the patient indicates to the medical practitioner his or her wish to proceed in pursuance of the request.

Family consultation

10.—(1) The attending medical practitioner shall strongly encourage the patient to notify or consult his or her family and others having close and affectionate ties with the patient of his or her request pursuant to this Act.

(2) The patient shall have full control and discretion over whom to notify or consult.

(3) A patient who declines or is unable to notify or consult his or her family and others having close and affectionate ties with him or her, shall not have his or her request denied for that reason.

Documentation and reporting requirements

11.—(1) The following shall be documented and filed in the patient's medical records:

(a) all oral and written requests made by a patient pursuant to this Act;

(b) the attending and consulting medical practitioners' diagnosis and prognosis; determination that the patient's suffering is severe, unrelenting and intolerable; determination that the patient is of sound mind, acting voluntarily and has made an informed decision;

(c) a report by the attending medical practitioner indicating that the patient had received palliative care that was reasonably available to him or her;

(d) the psychiatrist's report and confirmation that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment;

(e) the attending medical practitioner's offer to the patient to rescind his or her request at the time of the patient's second oral request; and

(f) a report by the attending medical practitioner indicating that all requirements under this Act have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed; and

(g) the reports of the attending and consulting medical practitioners of what they witnessed and did when the patient took the prescribed medication until the time of the patient's death.

(2) The attending medical practitioner shall submit the patient's medical records to the Review Committee after the death of the patient.

Review Committee

12.—(1) The Director shall cause a Review Committee to be established and maintained for the purposes of this Act. The committee shall comprise of one legal specialist who will serve as chair, one medical practitioner, one psychiatrist and one expert on ethical and philosophical issues.

(2) The Review Committee shall assess, on the basis of the patient's medical records referred to in section 11, whether the attending medical practitioner has acted in accordance with this Act.

(3) The Review Committee may request the attending and consulting medical practitioners and psychiatrist to supplement their reports verbally or in writing, where this is necessary for a proper assessment.

(4) Where the Review Committee is of the opinion that the attending medical practitioner did not act in accordance with the Act, the Committee shall notify the Public Prosecutor who then has the power to launch a criminal investigation to determine whether to charge the attending medical practitioner for the offence under section 14 of this Act.

Immunities

13.—(1) No medical practitioner shall be subject to civil or criminal liability or professional disciplinary action for any act done in accordance with this Act, who has acted with the reasonable standard of care expected of the medical profession.

(2) No medical practitioner shall be under any duty to participate in providing a patient with medication to end his or her life in a humane and dignified manner. If a medical practitioner is unable or unwilling to carry out a patient's request under this Act, he or she shall have the right to transfer the case to another medical practitioner.

Criminal Liability

14. Any attending medical practitioner who fails to act in accordance with the duties required of him or her under this Act shall be guilty of an offence and shall be liable on conviction to [an appropriate penalty].