Case Comment

WHEN DEATH KNOCKS, WHO WILL ANSWER AND WHAT WILL THEY SAY?

Re LP (adult patient: medical treatment)

[2006] 2 SLR 13

Re LP (adult patient: medical treatment) confronted, for the first time, the difficult question of whether an incompetent patient should be kept alive by invasive medical procedures notwithstanding an earlier indication (while competent) rejecting that procedure even if it would lead to her death. This case comment examines the approach taken by the court in arriving at the decision and analyses whether the approach is congruent with our legal jurisprudence and our moral instincts as to the practical consequences that the decision will engender. It also considers the direction that the law ought to take and the role of the courts in deciding such matters.

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I. Introduction

1 Given the advanced state of medical technology in Singapore, it was inevitable that the question of whether an incompetent patient (who had earlier, while competent, indicated that she did not consent to a certain medical procedure) should nevertheless be kept alive by that same procedure would arise. The recent decision by Justice Choo Han Teck in *Re LP (adult patient: medical treatment)*[1] throws up several important issues that threaten, as they have in other jurisdictions, to recur in even more dramatic factual scenarios. The aim of this case comment is to examine the approach taken by Choo J in arriving at his decision and to

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[1] [2006] 2 SLR 13 ("*Re LP*").

analyse whether the approach is congruent with our legal jurisprudence and our moral instincts as to the practical consequences that the decision will engender.

II. The facts of *Re LP*

2 Truth, as the cliché goes, is stranger than fiction. So is life. Mdm LP was a 51-year-old diabetic who admitted herself to Gleneagles Medical Centre in mid-October 2005. She complained of pain in both feet and was diagnosed as having a "right foot infection with gangrene of her right big toe and several superficial burn wounds over her left foot". Mdm LP also informed the physician, Dr Tan Mak Yong ("Dr Tan"), that she had already been to two other hospitals where she was told that her right leg had to be amputated. However, according to Dr Tan, Mdm LP refused to consent to the amputation of her right leg. She was, nevertheless, eventually persuaded to agree to the amputation of her right toe.

3 A month later, the infection had spread to her left leg. Nonetheless, she persisted in refusing an amputation of her legs, telling Dr Tan to "save her legs at all costs". At this time, there was no immediate danger of death.

4 Shortly after, the infection in her legs caused Mdm LP to suffer from septic shock and she lapsed into a coma as a result. Choo J accepted the evidence of Dr Tan and the other specialists who corroborated it that Mdm LP would die if her legs were not amputated. It was, however, never made known to Mdm LP that she would die if her legs were not amputated; although she had previously told her son, L, that she would "rather die than lose her legs".

5 The only family member that the hospital could reach was L, who was a minor. L's father was in the Philippines and could not be contacted. According to L, the father was rarely in touch with the family and had never married Mdm LP.

6 Choo J allowed the hospital's application to proceed with the amputation. However, in a strange twist of fate, Mdm LP woke up from her coma just as the hospital was about to prepare her for pre-surgery tests. It was reported in *The Straits Times* that her condition was stable but that she was unable to speak and had to breathe with the help of a machine. Dr Tan continued to believe that an amputation would be necessary if the infection flared up again. Mdm LP, on the other hand,

had yet to consent to an amputation of her legs at the time of the news report.[2]

III. What *Re LP* decided

7 After deciding that the court had jurisdiction to hear the application, Choo J proceeded to analyse the basis on which to decide whether to grant a declaration validating the legality of the proposed amputation. His Honour began by summarising the contrasting approaches in the US and the UK to the question of how a court should decide whether to authorise proceeding, continuing or ceasing to continue treatment when the patient was no longer competent to decide for herself.

8 As far as the US position goes, Choo J correctly encapsulated the gist of what has become commonly known as the "substituted judgment" test. This test seeks "evidential proof as to what the patient herself would do had she been conscious for a brief moment to be appraised of her condition and to give or withhold her consent as required".[3] As for the UK approach, Choo J characterised it as such:[4]

> While greater emphasis is placed on patient autonomy in America than in the UK, consent is still of paramount importance in the latter jurisdiction. Hence, if there is clear evidence of consent or refusal to consent to any medical treatment, doctors will have to respect the patient's decision. When it comes to a situation where the patient is incapable of giving her consent, or where such consent (or lack of it) was not made reasonably clear, the doctors would have to treat the patient according to what they think is in the best interests of the patient. ... The decision as to what is in a patient's best interests from the point of view of the doctors is strictly a medical one, and one that is expected to be professionally formed.

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[2] Radha Badsu, "Court gives OK to amputate legs ... then woman in coma wakes up; She fights doctors to keep her limbs even at the risk of losing her life" *The Straits Times* (26 January 2006).

[3] *Supra* n 1, at [8]. For the sake of context, it should be added that in most States in the US, the first layer of decision-making (in the absence of a prior arrangement, such as an advance directive) is not the courts, but the family. Most states provide for the automatic appointment of a health care proxy based on a fixed statutory hierarchy. In the majority of cases, this scheme resolves the issue; and the decision is taken without the requirement that the incompetent patient's actual prior preferences are effectuated. It is only in a minority of States that the appointed proxy is compelled to employ the substituted judgment test.

[4] *Supra* n 1, at [9].

9 It may be necessary to clarify the English position. It is true that the English courts accept the principles of self-determination and patient autonomy; however, this is only to a certain extent. Patients of sound mind may reject even life-saving medical treatment no matter how rational or irrational the decision may be.[5] Furthermore, for patients who were previously competent, Choo J was correct in observing that "if there is clear evidence of consent or refusal to consent to any medical treatment, doctors will have to respect the patient's decision".[6] In other words, the English courts have confirmed the legal effect of *anticipatory* decisions made by the *patient*.[7] The essential difference between the UK and US positions is that absent such a decision by the patient, the English courts will not go on to determine the patient's values, convictions and feelings in order to ascertain what the patient *might have decided* were she competent. Instead, the courts will proceed to the "straightforward" test based on the best interests of the patient.[8] This is where the English courts have truncated that principle of self-determination.

10 Choo J, however, may have been too quick to surmise that the English approach to the "best interests" test is that it is solely a medical analysis. To be sure, in the House of Lords' decision of *Airedale NHS Trust v Bland*,[9] four of their Lordships linked the "best interests" test to the *Bolam* test,[10] which meant that the decision as to whether a certain course

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[5] See, for example, *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871 ("*Sidaway*"); *In re T (Adult: Refusal of Treatment)* [1993] Fam 95 ("*Re T*"); *Airedale NHS Trust v Bland* [1993] AC 789 ("*Bland*"). On facts similar to *Re LP*, the court in *In re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290 ("*Re C*") granted an injunction in favour of a patient to prevent the hospital from amputating his leg which had become gangrenous. In summarising the case law to date, Thorpe J held at 294, citing Lord Donaldson of Lymington MR in *Re T* at 115 that:

> Prima facie every adult has the right and capacity to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even lead to premature death. Furthermore, it matters not whether the reasons for the refusal were rational or irrational, unknown or even non-existent.

[6] *Supra* n 1, at [9].

[7] *Re T*, *supra* n 5; *Bland*, *supra* n 5. See also *Re C supra* n 5.

[8] *Bland*, *supra* n 5. It has been questioned whether their Lordships misunderstood the nature of substituted judgment and whether their reliance on *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 ("*Re F*") was accurate: see Ian Kennedy & Andrew Grubb, *Medical Law* (Butterworths, 3rd Ed, 2000) at p 838.

[9] *Supra* n 5.

[10] The test in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 at 587 (the "*Bolam* test"). The test is that a doctor is not negligent if he or she acts "in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art … [even if] there is a body of opinion who would take a contrary view". In *Re F*, Lord Goff of Chieveley, at 78, also equated best interests

of treatment was in the patient's best interest would be assessed by reference to a practice accepted by a responsible body of medical opinion. This, as we know, means that the medical opinion will often be decisive. However, the cases that have followed appear to take a more holistic approach to the issue. In *In re A (Children) (Conjoined Twins: Surgical Separation)*[11] the English Court of Appeal noted several cases in which the best interests of the patient were not simply equated to the medical best interests of the patient but extended to all facets of the patient's life.[12]

11 Having set out these positions, Choo J decided that "[w]here doctors do not have a clear and express consent of their patient, their only course is to act in the best interests of the patient".[13] Because Mdm LP's desire that her legs be saved at all costs was not made in the knowledge that she would die without the amputation, Choo J was not prepared to accept that her refusal covered the present situation and therefore proceeded to decide the case based on whether the amputation would be in her best interests.[14]

12 What was interesting was how even though Choo J eventually thought that the "best interests" test amounted to a balancing of medical benefits and disadvantages under English law, his Honour recognised that the answer to what constituted the best interests of a patient could vary drastically among family members, physicians, and presumably the patient herself were she competent. Consequently, his Honour took into account L's testimony to the court that he was in a dilemma as to whether he would prefer the surgery to go ahead,[15] although he was also careful to stress that the best interests of a patient's family could never be *ipso facto* equated to the best interests of the patient.[16] Choo J then weighed these considerations against the medical possibilities and decided that the amputation was in Mdm LP's best interests.[17]

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with the *Bolam* test. This was roundly condemned in the UK Law Commission's Report on *Mental Incapacity* (Law Com No 231, 1995).

[11] [2001] Fam 147.

[12] See also, *In re Y (mental patient: bone marrow donation)* [1997] Fam 110 (taking into account emotional benefit); *Re A (medical treatment: male sterilisation)* [2000] 1 FCR 193 (taking into account emotional and other welfare concerns); *Simms v Simms* [2003] Fam 83 ("overall" best interests).

[13] *Supra* n 1, at [10].

[14] *Id* at [11].

[15] *Id* at [8].

[16] *Id* at [3] and [9].

[17] *Id* at [3].

13 The structure of how a court, relying on *Re LP*, may analyse future cases would be as follows. First, the court will examine whether the patient had made a clear and express pronouncement of whether she would accept or refuse the proposed course of treatment. The court also has to scrutinise carefully whether the decision was made in contemplation of the specific consequences that the patient now faces. This appears to be a narrow test. Even a remark that "I would rather die than lose my legs" will not suffice if it was not made in contemplation of advice that she *would* die without the operation. Second, if the patient had not made any such refusal or consent clear, then it falls to be decided whether the treatment will be in the patient's best interests. In this regard, medical opinion will have to be sought. It will also be helpful for the hospital, and the courts, to seek the opinion of the patient's family, although such opinion is not to be decisive or binding.[18] It is up to the court to weigh the opinion of these stakeholders.

14 Unfortunately, it was not made clear if Choo J accepted or rejected the substituted judgment test. On the one hand, it appears that his Honour did reject the test in holding that "[w]here doctors do not have a clear and express consent of their patient, their only course is to act in the best interests of the patient".[19] The language of this formula comes directly from his summary of the English position just one paragraph before. Hence, it could be assumed that the English approach prevailed. Furthermore, given that Choo J expressly mentioned that "if [the substituted judgment test] is the approach that we should follow, then the statements made by Mdm LP to her doctors to 'save her legs at all costs', and that she would 'rather die than lose her legs' to her son might become important evidence for me to consider",[20] His Honour's failure to consider these statements subsequently may be indicative that he had rejected the substituted judgment test.

15 However, another way of looking at the decision is to say that the reason Choo J did not explicitly analyse the application of the substituted judgment test is because, in any event, the test would have been unhelpful given the facts. No family members, relatives or friends testified apart from L. L himself did not suggest that if told of the probability of death, Mdm LP would still have refused the amputation. Moreover, when Mdm LP was lucid and competent, she did not express that her refusal to

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[18] *Id*, at [9].
[19] *Id*, at [10].
[20] *Id*, at [8].

amputate was based on any particular moral or religious conviction or even an irrational fear. Hence, her request to save her legs might simply have been to avoid giving her doctors the "easy option" of amputation for as long as possible. As such, the evidence was equivocal and it was impossible to construct the mind of Mdm LP in order to evaluate whether she would have consented to the amputation had she known that she faced certain death otherwise. If this was the case, the question of whether the substituted judgment test will apply in a future case where more information is available is still open.

IV. Analysis of *Re LP*

16 Several issues of philosophical and practical import loom large. My aim in this case comment is modest. I shall deal only with the following. First, I will examine whether the "clear and express" standard that Choo J adopted in assessing the patient's prior wishes is desirable. Second, I will seek to analyse whether the substituted judgment test ought to be accepted by the Singapore courts; and if so, how it may relate to the "best interests" test. Third, I will examine how the "best interests" test should be approached. Fourth, I will raise the issue of whether the courts should be involved in decisions like *Re LP*; and if so, what role they might play.

A. Anticipatory decisions: What standard?

17 Courts in both the UK and the US generally accept the *principle* that if a patient had previously been competent, her refusal to accept treatment is to be taken into account and given effect to when she is no longer competent, even if this means that she will die.[21] However, the *evidentiary* standard that is required simultaneously reflects an instinctive reluctance to give effect to such refusals. In *Re T*, the patient was admitted to hospital because she was injured in a car accident. She was also 34 weeks pregnant. When the topic of a possible blood transfusion was raised, T told the staff nurse that she believed blood transfusion to be a sin and a bar to eternal salvation and therefore refused it. She then went into labour and the hospital decided to deliver the baby by Caesarean section. T told the hospital staff again that she did not want a blood transfusion and signed a form to that effect. The case eventually reached

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[21] In Missouri, however, even clearly proven wishes may be limited by the State's interest in the preservation of life: *Cruzan v Harmon* 760 SW2d 408 (Mo, 1988) (*en banc*); *Cruzan v Director, Missouri Department of Health*, 497 US 261 (1990).

the English Court of Appeal, which held that the refusal was simply not specific enough and not made in the knowledge that she might die without the transfusion. In other words, for an anticipatory refusal to be valid, the patient must intend her refusal to apply to the specific circumstances that have arisen – even if it is clear that the refusal is based on something which is unlikely to change overnight, such as religious beliefs.

18 The US state courts have also insisted on "clear and convincing" evidence that the patient intended to refuse the particular treatment. The evidence has to be "so clear as to leave no substantial doubt"[22] or "sufficiently strong to command the unhesitating assent of every reasonable mind".[23] In *Cruzan v Harmon*,[24] Robertson J, in the Missouri Supreme Court, held that a refusal of medical treatment must be based on "a clear understanding of the risks and benefits of the proposed treatment, alternatives or nontreatment, along with a full understanding of the nature of the disease and the prognosis".[25] It is therefore "definitionally impossible for a person to make an informed decision … under hypothetical situations".[26] And, in New York, the Court of Appeal held that "nothing less than unequivocal proof will suffice when the decision to terminate life support is at issue".[27]

19 As noted above, Choo J in *Re LP* did not explicate what would satisfy the requirement of "clear and express" evidence of a patient's prior consent or refusal to consent to a medical treatment. However, the tenor of the decision seems to imply a heavy burden on those seeking to rely on a previously competent patient's anticipatory decision. As the judge explained, a patient's prior refusals to consent must be made in the knowledge that this was the only treatment that could save her from impending death.[28] Even a statement that "I would rather die than lose my legs" which would appear, at first blush, to be wide enough, will not be upheld if it is not made with the benefit of medical advice of impending death.

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[22] *Sheehan v Sullivan* 126 Cal 189 (1899) at 193.

[23] *Lillian F v Superior Court* 160 Cal App 3d 314 (1st Dist, 1984) at 320.

[24] *Supra* n 21.

[25] *Id*, at 417

[26] *Ibid.*

[27] *In the matter of Westchester County Medical Center, on Behalf of Mary O'Connor* 72 NY 2d 517 (1988) at 521.

[28] *Supra* n 1, at [11].

20 On the assumption that it would be ideal to give ethical priority to the wishes of the incompetent patient, requiring a patient to have foreseen the specific situation which she is now in when she expressed her desire to reject treatment poses difficulty. This is because, as a matter of practical reality, there will be very few cases in which that will happen. Given the infinite variety of ways in which death may confront us, any expression of our desire to reject certain medical treatment is necessarily hypothetical. It is unrealistic to expect individuals to make their anticipatory decisions by sitting down with their doctors and mapping out every conceivable medical crisis that they may face. If the courts insist on a relatively high standard of proof before anticipatory decisions are given effect, many perfectly valid wishes may be thwarted.

21 Even doctors cannot predict the exact circumstances that we may face down the road. In *Re T*, for instance, the patient was suddenly in need of a blood transfusion when just shortly before, she was told that a blood transfusion was rarely necessary in Caesarean sections. In *Re LP*, the doctor himself did not foresee that the infection would spread so virulently such that Mdm LP would die if her legs were not amputated. Medical advice of impending death would also be impossible in cases where the dilemma is occasioned by an unexpected accident or medical emergency. As the Ontario Court of Appeal astutely observed in *Malette v Schulman*,[29] the whole point of an anticipatory decision is for it to govern in circumstances where the patient can no longer be advised.

22 A stringent evidentiary standard may be explicable on the basis that it serves "legitimate state interests in protecting life and in preventing erroneous determinations about what the patient had chosen when she was competent".[30] These objections do not, in my opinion, justify the standard currently imposed on anticipatory decisions.

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[29] (1990) 72 OR (2d) 417; [1990] 67 DLR (4th) 321.

[30] John A Robertson, "Cruzan and the Constitutional Status of Nontreatment Decisions for Incompetent Patients" (1991) 25 Ga L Rev 1139 at 1164. I do not intend to address in detail the more basic philosophical dispute as to whether a patient who was previously competent can be said to be? the same person as her now-incompetent self such that we should assume that her prior wishes carry moral authority. See Rebecca Dresser, "Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law" (1986) 28 Ariz L Rev 373 at 379–381; Rebecca Dresser, "Relitigating Life and Death," (1990) 51 Ohio State LJ 425 at 431–434; Derek Morgan, "Odysseus and the Binding Directive: Only a Cautionary Tale?" (1994) 14 LS 411; *cf* Ronald Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia and Individual Freedom* (Alfred A Knopf, 1993). Dworkin argues that a patient's critical interests survive her incompetence and that respecting someone's

23 The State's interest in protecting life is an important one but it is somewhat of a red herring in this debate. If anticipatory decisions violate the sanctity of life, then the solution must be to ban all such decisions. A person who conscientiously rejects treatment knowing that he will die cannot be in a better moral position than a person who rejects treatment not knowing that he might die as a result. Quite the contrary, I submit. As such, the State's interest in protecting life does not explain the high evidentiary standard imposed.

24 Furthermore, it is not disputed that the State's interest in protecting life usually gives way when it conflicts with a competent patient's autonomy in deciding to reject potentially invasive medical treatment. The latter has tended to prevail either because the courts have found a constitutional liberty interest[31] or because of the established common law principle that forced treatment constitutes battery. And it has never been the case that a competent patient's refusal to consent to treatment would be subject to scrutiny. Her decision may be wholly unreasonable and irresponsible; she may even refuse to hear her doctor's advice on the matter. But once she says "no" there is little doubt that her refusal to consent is valid and binding on all concerned. It is difficult to see why it should be any different when it comes to an incompetent patient who has made an anticipatory decision when she was competent. The fact that a person makes an anticipatory refusal to consent to treatment but may not have foreseen the *exact* circumstances that

prior wishes even when they are no longer competent serves to "encourage and protect people's general capacity to lead their lives out of a distinctive sense of their own character, a sense of what is important to and for them": *id*, at p 224. There is no doubt, he argues, that people treat the manner of their deaths as of special and symbolic importance to their lives: *id*, at p 211. Furthermore, the argument that giving effect to a patient's *prior* wishes is wrong because it may fail to take into account the patient's *present* interests is mistaken on two levels. At the first level, the argument cuts both ways. It may be *against* her present interests to cease treatment but it may also be *in* her present interests to cease treatment. At the second level, such an argument confuses the critical interests of the patient (*ie*, her values, wishes and desires) with her medical interests. It may not be medically beneficial for the patient to cease treatment in that she may have a good chance of recovery but so long as the decision is in accordance with her critical interests, the principle of patient autonomy suggests that the latter must prevail. In any event, I do not address this debate because it is settled law that verifiable anticipatory decisions are to be given effect. *Re LP* also endorses this principle. The only question is how high to pitch the evidentiary requirement.

[31] *Cruzan v Director, Missouri Department of Health supra* n 21. The US Supreme Court held at 278 that "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions".

subsequently arise should not change the analysis. After all, we make all sorts of decisions that will impact us in the future in ways we cannot even begin to contemplate. Of course, it might be asked whether such a claim undermines the informational component of the valid expression of autonomous choice. The answer is that it does not. While patients have a *right* to seek information and a doctor's refusal to do so or the inadequacy of the advice may vitiate that choice, that is quite a different proposition from saying that patients are *obliged* to inform themselves of the consequences of their decisions.[32]

25 Perhaps the argument might be that allowing patients to refuse treatment prospectively would lead to a culture in which suicide and euthanasia would be tolerated.[33] But it is not evident that forbidding incompetent patients to refuse treatment is any more likely to prevent this slippery slope than allowing a competent patient that same choice. In any event, the causal link between giving effect to a previously-competent patient's wishes and tolerating suicide and euthanasia is demonstrably feeble.[34] That the link between the two is unpersuasive was accepted by the Singapore government in its enactment of the Advance Medical Directive Act.[35]

26 I would also question the assumption that underlies the present approach, which is that no real harm accrues by continuing with the *status quo* or by insisting on medical treatment. For one, the patient must suffer the indignity of being forcibly treated even though she might have preferred otherwise. Where that preference is based on religious grounds, the damage is even more obvious because the patient will live – or die –

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[32] *Re C*, *supra* n 5.

[33] See, for example, *In the matter of Clare C Conroy*, 486 A 2d 1209 (1985) ("*Conroy*") at 1224. The court considered but ultimately rejected the analogy. Prof Robert Burt has also persuasively argued that even though the distinction between physician-assisted suicide and the withholding or withdrawal of life-sustaining treatment may be illogical, the line drawn between them serves a protective function in so far as it promotes conscious acknowledgement of our moral discomfort with purposeful killing: Robert A Burt, "The End of Autonomy" Hastings Cent Rep 2005; 35(6) Spec No; S9–13 at S 11–12. Therefore, it is not at all inevitable that giving effect to the anticipatory wishes of presently-competent patients in respect of life-sustaining treatment will lead to the toleration of suicide and euthanasia.

[34] *Conroy*, *supra* n 33. See also Phillip Peters Jr, "The State's Interest in the Preservation of Life: From *Quinlan* to *Cruzan*" (1989) 50 Ohio State LJ 891.

[35] Cap 4A, 1997 Rev Ed. See *Singapore Parliamentary Debates*, *Official Report* (5 December 1995), vol 65 at col 351. It may be questioned if the Act fully vindicates autonomous choice because it does not seem to allow for a patient to indicate if she does not want even palliative care or food. However, the Act is facilitative and does not purport to pre-empt the rights of patients: see, *infra* n 46.

carrying the burden of having committed a mortal sin.[36] Moreover, there may be cases where insisting on treatment produces medically grotesque results. One commentator has, in vivid detail, described the agonising death of Shiela Pouliot, a 42-year-old woman who was ordered to be given artificial nutrition and hydration. However, because the nutrition could not prevent protein starvation, her body began to catabolise her own tissue, causing severe oedema to the point where her skin was stretched, peeled off and left painful raw patches. She was, in essence, eating herself calorically to death. She remained in this condition for two months before she finally passed away.[37]

27 Insisting on a high evidentiary threshold may also result in unintended consequences. For instance, family members and friends may manufacture detailed conversations with the patient so as to convey the impression that the latter had contemplated the situation she is now in when she made her decision to refuse treatment.[38] It might also create a perverse incentive for those who cannot bear the thought of a "living death" to take their own lives before that happens,[39] thus encouraging the very violation of the sanctity of life that the State hopes to avoid.

28 In the end, the only plausible rationale for the high evidentiary threshold may be the State's interest in protecting the *patient's* own interests. In other words, the stringent requirement is to prevent the possibility of terminating life-saving treatment when the patient may not actually have wished for it. Even so, the test is an overkill. The Advance Medical Directive Act itself does not impose such a high burden. All that it requires is that one of the witnesses, who must be a medical practitioner, "take *reasonable steps in the circumstances* to ensure that the

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[36] Tom Stacy, "Death, Privacy, and the Free Exercise of Religion," (1992) 77 Cornell L Rev 490; Andrew Grubb, "The Persistent Vegetative State: A Duty (Not) to Treat and Conscientious Objection" (1997) 4 EJHL 157. See also Ronald Dworkin, *supra* n 30.

[37] Alicia R Ouellette, "When Vitalism is Dead Wrong: The Discrimination Against and Torture of Incompetent Patients by Compulsory Life-Sustaining Treatment" (2004) 79 Ind LJ 1. MCS (minimally conscious state) patients – somewhere between sapient consciousness and the persistently vegetated state – are also likely to suffer physical pain from continued treatment in some circumstances. See Michelle M Mello, "Death, Life, and Uncertainty: Allocating the Risk of Error in the Decision to Terminate Life Support" (1999) 109 Yale LJ 635.

[38] Norman L Cantor, "Discarding Substituted Judgment and Best Interests: Toward a Constructive Preference Standard for Dying, Previously Competent Patients Without Advance Directions" (1996) 48 Rutgers L Rev 1193 at 1207.

[39] This might perhaps be more relevant in cases where the dreaded illness is progressive, for example, Alzheimer's disease. See Eric Rakowski, "The Sanctity of Human Life" (1994) 103 Yale LJ 2049 at 2107.

patient has been informed of the nature and consequences of making the directive".[40] Presumably, the medical practitioner is not obliged to force the patient to accept medical advice if she chooses not to. Furthermore, the directive is executed once it is determined that the patient is terminally ill. Yet, within the confined territory of terminal illness, some will be more imminent than others, some more painful, others more humilitating. The Advance Medical Directive Act makes no distinction between these scenarios. Neither does it require that there be scrutiny of whether the patient has contemplated the exact circumstances that she subsequently faces. A general contemplation that death will result or be accelerated by forgoing treatment is sufficient.

29 Even if it was thought that a high evidentiary standard was necessary, the courts should not focus solely on the patient's prior statements. Where the actual expression of the once-competent patient's rejection of treatment is not terribly conclusive, it does not *ipso facto* mean that the courts can never be certain that the patient did not intend for her statement to apply to the particular situation which she is currently in. Taking the facts of *Re T*,[41] for instance, it is true that the patient's refusal to consent to a blood transfusion was made without knowing that it might save her life. But a court could turn to her family to fill in the gaps. The family might inform the court that she was raised in a family of Jehovah's Witnesses and that her rejection of blood transfusion was based on a religious tenet.[42] The family might also point out that this religious tenet was to be obeyed regardless of the fact that one might die. If such information was forthcoming, then the patient's prior decision to reject treatment may be given effect to without anxiety that the patient did not intend it to apply to the present circumstances. As such, consideration of the context in which the statement was made as well as other extrinsic information may give the statement added clarity.[43]

30 On the facts of *Re LP*, such information was not forthcoming, and it was probably correct of Choo J to have rejected Mdm LP's previous statements as amounting to an anticipatory decision. Were there to be a

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[40] Section 4(*d*) of the Advance Medical Directive Act, *supra* n 35 [emphasis added].

[41] *Supra* n 5.

[42] It was found that T's mother had exerted undue influence on her and as such T's refusal was vitiated. However, the English Court of Appeal did go on to consider the notion of anticipatory decisions in principle.

[43] Mark Strasser argues that a high evidential threshold frustrates the role of the family in the decision-making and that they may play a useful role in ascertaining what the patient intended: see "Incompetents and the Right to Die: In Search of Consistent Meaningful Standards" (1995) 83 Ky LJ 733.

case where the ambient circumstances allow an inference that the patient intended her earlier statements to be applicable in the situation she is now in, it remains to be seen if the courts will nonetheless insist on an explicit and unambiguous statement made in the knowledge that she will die without the necessary treatment.

31 At the end of the day, the courts must be realistic. As Simons J pointed out in dissent in *In re Westchester County Medical Center*,[44] there are ways and means to avoid giving effect to a patient's anticipatory decision. One can always say that the decision was not made seriously enough, or that it was made in contemplation of an eventuality that was qualitatively different from the situation the patient now faces, and so on. But lay persons are not physicians and lawyers and a fetishist insistence on precision will not always produce a just result. As Simons J put it:[45]

> In short, [the patient] expressed her wishes in the terms only familiar to her, and she expressed them as clearly as a lay person should be asked to express them. To require more is unrealistic, and for all practical purposes, it precludes the right of patients to forgo life-sustaining treatment.

32 A final observation may be made. Regardless of the standard of proof required by the courts in Singapore, *Re LP* represents a significant shift towards recognising the principle of patient autonomy, well beyond the confined ambit of the Advance Medical Directive Act.[46] It would appear that patients may now make anticipatory decisions refusing medical treatment that would apply even if the treatment would *save* their lives, and not just where it would *prolong* an incurable suffering.[47]

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[44] *Supra* n 27.

[45] *Id*, at 532. In this case, the New York Court of Appeals found that:

> Her comments – that she would never want to lose her dignity before she passed away, that nature should be permitted to take its course, that it is "monstrous" to use life-support machinery – are, in fact, no different than those that many of us might make after witnessing an agonizing death.

Yet, one would have thought that a remark made after witnessing an agonising death is precisely when clarity is greatest because the knowledge of how death may turn out is presented in full force, as opposed to a statement made *in vacuo*.

[46] It should be noted that the Advance Medical Directive Act, *supra* n 35, does not purport to undermine the common law development of the right to refuse treatment: see s 13(1). In answering the concern of whether the directive promotes the "right to refuse treatment" the Select Committee on the Advance Medical Directive Bill stated that "patients who are competent will always have the right to refuse treatment, with or without the directive". See *Report of the Select Committee on the Advance Medical Directive Bill (Bill No 40/95)* (Parl 1 of 1996, 11 March 1996) at [24] and [25].

[47] The Advance Medical Directive Act currently only allows a person to dictate the cessation of "extraordinary life-sustaining treatment in the event of his suffering

This would mean that Choo J (though this is not made explicit) rejected the waxing and waning approach adopted in *In the Matter of Karen Quinlan*,[48] where the State's interests in the continuation of the patient's life increase as the prognosis gets better and the burdens of treatment diminish, and *vice versa*. All patients – whether their illness is curable or not, and whether the burden of treatment is great or minimal – have an equal right to reject treatment.[49]

B. Substituted judgment

33 In *Re LP*, Choo J did not consider whether and in what circumstances the substituted judgment test ought to apply, or if it ought to be rejected wholesale. His Honour, in the absence of a clear and express anticipatory decision by the patient, directly proceeded to analyse the case in terms of the patient's best interests. As suggested, it is, however, possible to read *Re LP* narrowly such that the question of whether the test ought to be applied where the evidence allows it is kept alive.[50] My view is that the substituted judgment test should not be discarded and that evidence of what the patient might have chosen – even if it does not rise to the level of a clear and express anticipatory decision – ought not to be disregarded.

34 If we accept that competent persons may make anticipatory decisions about their medical care, which *Re LP* did, it must follow that "there is a sense in which our interests can survive us".[51] These interests may be personal – our beliefs about which medical treatments are moral, how one should die, and so on. These interests may also be familial – we may be concerned about how our loved ones will fare after our deaths, or how they would cope emotionally or financially in the event that our

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from a terminal illness". See s 3(1) read with s 2 of the Advance Medical Directive Act, *supra* n 35.

[48] 355 A 2d 647 (1976), *certiorari* denied, 429 US 922 (1976).

[49] 355 A 2d at 664. This test was rejected by the same court in *Conroy*, *supra* n 33, at 1226: "[A] young, generally healthy person, if competent, has the same right to decline life-saving medical treatment as a competent elderly person who is terminally ill."

[50] It is also possible to read *Re LP*, *supra* n 1 as invoking the substituted judgment test, albeit within the best interests framework. But, as Lord Donaldson MR's decision in *Re T*, *supra* n 5, shows, it would be a leap to argue that endorsement of the substituted judgment test within the best interests framework would suggest a willingness to apply the substituted judgment test by itself.

[51] Allan Buchanan, "Advance Directives and the Personal Identity Problem" (1998) 17 Philosophy & Public Affairs 227 at 278, fn 1.

process of death is prolonged.[52] These are legitimate considerations that are reflected in anticipatory decision-making.

35 But what happens when we have not at all, or with sufficient clarity, indicated our refusal to accept treatment under certain circumstances? The fact that we may not have contemplated death or our manner of death in the exact and specific situation in which we subsequently find ourselves does not necessarily mean that our critical interests and legitimate concerns should be ignored. Many of us may not like to think about our deaths but it does not follow that we do not care about the manner in which we die.

36 If our concern is to vindicate the dignitarian and autonomy concerns of the patient,[53] the substituted judgment test, which requires the court to "don the mental mantle of the incompetent" in order to ascertain what the patient might have chosen, best vindicates these aims.[54] It is certainly true that, in a sense, the test involves a legal fiction or a rhetorical sleight of hand because the patient is not actually exercising her own right to refuse or consent to treatment.[55] A proxy is exercising that choice on her behalf. But, in my view, there is no reason why, especially in the absence of an anticipatory decision, we ought not to strive to "maintain the integrity of the person" by "acting toward her 'as we have reason to believe [she] would choose for [herself] if [she] were [capable] of reason and deciding rationally".[56] By examining the patient's critical interests, the substituted judgment test offers the closest approximation to what the incompetent would have wanted. This attempt at gauging what the patient would have desired should not be slighted. It is a genuine attempt at vindicating the critical interests of the patient. To be sure, one can never be completely assured that the correct result will be obtained – but the "best interests" test cannot guarantee that either.

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[52] The complex relationship between the patient's wishes and her family's desires and expectations is also the point that Prof Robert A Burt presses in "Family Conflict and Family Privacy: The Constitutional Violation in Terri Schiavo's Death" (2005) 22 Const Comment 425, especially at 431–433.

[53] Prof Burt has argued that it may be time to move away from the autonomous choice framework in end-of-life decision-making: *supra* n 52.

[54] *Belchertown State School Superintendent v Saikewicz* 370 NE 2d 417 (1977) ("*Saikewicz*") at 431. This case has been criticised for muddying the waters by applying the substituted judgment test where the patient had never been competent.

[55] On the history of how the test came to be, see Louis Harmon, "Falling Off the Vine: Legal Fictions and the Doctrine of Substituted Judgment" (1990) 100 Yale LJ 1.

[56] John Robertson, "Organ Donations by Incompetents and the Substituted Judgment Doctrine" (1976) 76 Colum L Rev 48, at 63, citing John Rawls, *A Theory of Justice* (Harvard University Press, 1971) at p 209.

37 The danger of applying the "best interests" test in the absence of an anticipatory decision is this. Under the "best interests" test, medical treatment is likely to be affirmed when it would probably save the life of the patient. However, if the patient recovers, she becomes *aware* that her critical interests have been denied, which is likely to cause her to feel that her sense of dignity has been violated. It may even, as pointed out, cause her much psychic stress and conflict if her prior wishes or critical interests were grounded in religion or a deeply-held moral conviction. In other words, the situations in which the "best interests" test would suggest sustaining medical treatment are, paradoxically, precisely the situations in which the courts will have to be more cautious because the patient is more likely than not to recover and discover what was done to her body.

38 That is not to say that the "best interests" test should be junked. It is still important in cases where the substituted judgment test cannot yield a conclusive answer. This will be considered below. It is also useful in *conjunction* with the substituted judgment test in the following way. When evidence of a patient's critical interests is strong, the courts will – and should – give effect to those interests. But there may be borderline cases where the court is not utterly convinced that the patient would have chosen to forgo medical treatment. In these cases, the court may look to the objective medical evidence on the basis that, more often than not, a patient will take into account her medical prognosis. Therefore, if the prognosis is good, the court may err on the side of affirming the treatment; and conversely, if the prognosis is discouraging, the court should discontinue treatment. In other words, where there is only some trustworthy (though not entirely unambiguous or convincing) evidence that the patient would have wanted to cease treatment, and the medical prognosis is poor, the court would not be remiss in ordering the cessation of her treatment. Of course, there will be cases where both the subjective evidence of the patient's desires and the objective medical facts are borderline. In these cases, the court will have to do its best to balance the State's and patient's interests in protecting the autonomy and welfare of the patient.[57]

39 Thus, rather than simply relying on *either* ambiguous subjective evidence *or* ambiguous objective evidence, which may require the application of a presumption in favour of or against treatment in order to break the tie, simultaneous consideration of all the evidence is more likely to produce a result that reconciles respect for the patient's interests in

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[57] Phillip Peters Jr, *supra*, n 34, at 939–940.

controlling her future medical care and her interest in treatment decisions that advance her welfare. Where borderline objective medical evidence can reinforce the probative value of borderline subjective evidence, and *vice versa*, this should be done.[58]

40 Two further observations may be made. First, the courts should be wary of pitching the evidential standard too high in ascertaining the critical interests of the patient. This will not only undercut the patient's critical interests, it would also, for all intents and purposes, be tantamount to asking whether the patient had conducted herself in a manner that will lead one to conclude that she undoubtedly would have rejected the treatment, *ie*, that she had made a clear and express indication that she would have wanted to reject or accept treatment. This appears to conflate the pure autonomy model reflected in the effectuation of anticipatory decisions with the substituted judgment. Secondly, if the substituted judgment test is about constructing the mental mantle of the patient, the patient's family and friends are obviously key to the exercise. Thus, the discussion below as to the participation of the family in the litigation process is equally relevant under the substituted judgment test.

C. The "best interests" test: What factors ought to be considered?[59]

41 In the absence of any reliable subjective evidence as to the patient's anticipatory decisions or her critical interests, or where the patient has never been competent, the "best interests" test has been adopted by most courts in order to determine whether to order the withholding or continuation of treatment. Similarly, in *Re LP*, Choo J

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[58] *Id*, at 923–925. This approach is not to be confused with the approach of incorporating the substituted judgment test within the framework of the best interests test. The difference, as I see it, lies in the ultimate focus. Under this proposed framework, the focus is still on vindicating the patient's autonomy; whereas under the "best interests" framework, the putative views or choices of the patient are only relevant but not decisive. In *Re T* (*supra* n 5), Lord Donaldson MR appeared to take the view that the putative choice of an incompetent patient (*ie*, substituted judgment) ought to be taken into consideration in forming a judgment as to what is in the best interests of the patient. See also s 4(6) of the Mental Capacity Act 2005 (c 9) (UK) where the judge is to consider, in applying the best interests test: (a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity); (b) the beliefs and values that would be likely to influence his decision if he had capacity; and (c) the other factors that he would be likely to consider if he were able to do so.

[59] I do not consider the question of how extreme the patient's condition must be before treatment will be considered as not being in the patient's best interests. This is because the point was not raised in *Re LP (supra* n 1) For this, see Kennedy & Grubb, *supra* n 8, at pp 2173–2174.

held that in the absence of a clear and express articulation of the patient's advance consent or refusal to consent to treatment, the only course for the doctors and the court is to act in the best interests of the patient.

42 The "best interests" test may be justified on the basis that it may be assumed that most persons make decisions based on their best interests. Therefore, even in the absence of proof of the patient's subjective intentions, decisions based on the "best interests" test will still tend to vindicate the dignitarian concerns of incompetent patients.

43 If the "best interests" test is adopted, the question arises as to what factors ought to count in the analysis. For starters, it is necessary to reject the position that the best interests of a patient fall to be determined solely or even predominantly by the medical profession. Such an approach is unjustifiably narrow. As Lord Mustill put it in *Bland*:[60]

> [I]t may be said that the decision is ethical, not medical, and that there is no reason in logic why on such a decision the opinions of doctors should be decisive.

In the Court of Appeal, Hoffmann LJ (as he then was) also argued that:[61]

> [T]he medical profession can tell the court about the patient's condition and prognosis and about the probable consequences of giving or not giving certain kinds of treatment or care, including the provision of artificial feeding. But whether in those circumstances it would be lawful to provide or withhold the treatment or care is a matter for the law and must be decided with regard to the general moral considerations of which I have spoken.

Such sentiments are undoubtedly correct. Whether to order the cessation or continuation of treatment involves a consideration of the medical circumstances. However such decisions are also ethical and legal in nature and the medical profession cannot claim to have a monopoly on such issues.

44 As pointed out, Choo J, at minimum, thought that the views of the patient's family should matter. He also appreciated that in analysing of what constituted the patient's best interests, one should be sensitive to context.

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[60] *Supra* n 5, at 898.

[61] *Id*, at 834 (CA).

45 If the best interests test is also an attempt at gauging what the patient would have chosen, the contextual approach employed in *Re LP* is salutary. After all, it is obvious that we do not make decisions about our healthcare solely based on the medical facts.[62] For example, even if a procedure may sustain our lives indefinitely, we may not think it worthwhile to go though with it because the quality of our lives thereafter would be so terrible. Thus, decisions that focus exclusively on factors such as pain (in *In re Conroy*[63]) and the length of life (in *Cruzan v Director, Missouri Department of Health*)[64] would produce all sorts of counterintuitive results. A patient who is in a persistently vegetated state is not able to suffer any pain and could, technically, be kept alive for a relatively long amount of time. Thus, if pain and/or length of life is the touchstone, it would justify forcibly keeping the patient on life support indefinitely – even if there will never come a day when the patient will recover and even though her current condition, as was the case in *Bland*,[65] is somewhat grotesque because she has to be fed though a nasogastric tube, have her bladder emptied by a catheter, her bowels evacuated by enema and has to be repeatedly treated for infection in various parts of the body. However, it should be pointed out that the fact that one suffers pain or limitations in life does not necessarily mean that one's quality of life is destroyed.[66]

46 Adopting an approach that allows a judge to consider the patient's quality of life is therefore sensible. There is, however, a concern that quality of life considerations may simply be a Trojan horse and that judges would be playing God in deciding the "worth" of the patient. But a quality of life standard need not and does not involve comparison of the worth of the patient and others as the basis of treatment. It merely calls for the examination of the *patient's* own quality of life presently and

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[62] For an analysis of how patients make health care decisions – which is quite different from how the medical professionals would decide – see Paul Tan, "The Doctrine of Informed Consent – When Experts and Non-Experts Collide" [2006] Sing JLS 148. Lord Scarman, in *Sidaway*, *supra* n 5, at 652, also acknowledged the diverse considerations that patients take into account in deciding whether to consent to a proposed course of treatment.

[63] *Supra* n 33.

[64] *Supra* n 21.

[65] *Supra* n 5.

[66] See Adrienne Asch, "Recognizing Death While Affirming Life: Can End of Life Reform Uphold a Disabled Person's Interest in Continued Life?" Hastings Cent Rep 2005; 35(6) Spec No: S31–36.

whether it would be improved by the continuation of treatment.[67] As one commentator has described it:[68]

> Every *person* is of "equal value." But not every *life* . . . is of equal value if we are careful to unpack the terms "life," "equal," and "value." If "life" means the continuation of vital processes but in a persistent vegetative state; if "value" means "a good to the individual concerned"; if "equal" means "identical" or the "same," especially of treatment, then I believe it is simply false to say that "every life is of equal value."

47 The factors to be considered in ascertaining the patient's quality of life are necessarily fluid and open-ended. It would take into consideration the continued burden and invasiveness of the treatment, the mental and physical stress that the treatment would impose, whether the patient would regain control of her bodily functions, whether the patient would be capable of forming personal relationships in the future,[69] and so on. The courts should also be mindful that we are assessing the quality of life of the patient, and not a hypothetical person. Thus, the courts are not disentitled from considering such factors as the mental retardation of the patient if it would affect, for instance, her ability to comprehend the treatment, which may in turn prevent her from appreciating that the treatment would assist in her eventual recovery.[70]

48 A tricky question in relation to what factors to consider in applying the "best interests" test is whether the views of the family should be included in the calculus. Choo J seems to have thought so, going as far as to suggest that the opinions and sentiments of the patient's family ought to be sought[71] and that their views may be weighed against the

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[67] Kevin Quinn, "The Best Interests of Incompetent Patients: The Capacity for Interpersonal Relationships as a Standard for Decisionmaking" (1988) 76 Cal L Rev 897 at 927.

[68] *Ibid*, citing Richard McCormick, "The Quality of Life, The Sanctity of Life" Hastings Cent Rep 1978; 8(1): 30–36 at 32–33. Another way of looking at the issue is to distinguish between the worthwhileness of the *treatment* and of the *patient*. Either way, it is possible to reach a decision, consistent with the sanctity of life, that life support should be ceased. See John Keown, "To Treat or Not to Treat: Autonomy, Beneficence and Sanctity of Life" (1995) 16 Sing L Rev 360.

[69] See generally Kevin Quinn, *supra*, n 67. In *In re Matter of Beth Israel Medical Center* 519 NYS 2d 511 (1987) at 517, the court in applying the "best interests" test relied not on pain and suffering (which could not be discerned) but rather on the diminished quality of existence – absence of meaningful intellectual capability, complete immobility, complete helplessness and the lack of any intellectual or emotional benefit to the patient in staying alive. The court also helpfully enumerated a non-exhaustive list of 12 factors to take into consideration in deciding what is in the best interests of a patient.

[70] See Phillip Peters Jr, *supra* n 34, at 947, citing *Saikewicz*, *supra* n 54.

[71] *Supra* n 1, at [9].

medical possibilities.[72] We may distinguish the views of the patient's family into three categories: (a) those views that go towards establishing the *patient's* likely views on the issue; (b) those views that establish the *family members*' views as to the best interests of the *patient*; and (c) those views of the family that reflect *their* own interests in the matter. The first category of views is not really controversial in the sense that the natural starting point in finding out whether the patient has made an anticipatory decision or what the critical interests of the patient might be for purposes of the substituted judgment test is the patient's family.[73] The second and third categories are more widely debated, in particular, because they go against the convention that the views of the family ought to be permitted only in so far as they reflect the views of the patient, out of fear that the family might end up supplanting the patient's choice.[74] However, in *Re LP*, Choo J appeared to take cognisance of the patient's son's opinion as to whether *he* would have preferred the hospital to proceed with the amputation.[75]

49 This broader inclusion of the views of the patient's family is enlightened. In my view, the focus on patient autonomy and the anxiety to ensure that the decision, as to whether to continue or terminate treatment, properly reflects the best interests of the patient ought not to blind us to the fact that we are seldom, if ever, free-standing automatons. Rather, we are invariably embedded, first and foremost, in our families. Therefore, our best interests are not necessarily opposed to – but are often congruent with – our families' own views about how we should make life and death decisions.[76] In fact, studies reveal that many prefer their

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[72] *Id*, at [3].

[73] Although, of course, there is always the risk that the family may misinterpret the desires of the patient, or there may be disagreement among family members, or that their views are coloured by other motivations: see *Cruzan v Director, Missouri Department*, *supra* n 21, at 281, 285–287 (*per* Rehnquist CJ); Lois Shepherd, "Shattering the Neutral Surrogate Myth in End-of-Life Decisionmaking: Terri Schiavo and Her Family" (2004) 35 Cumb L Rev 575 at 578–584 (noting the difficulties in relying on the views of a patient family). For this reason, it may be necessary for the court to scrutinise the evidence presented by family members to ensure that no ulterior motives may be lurking in the shadows.

[74] *In re Guardianship of Browning*, 568 So 2d 4 (1990) at 13. See Kathleen Boozang, "An Intimate Passing: Restoring the Role of Family and Religion in Dying" (1997) 58 U Pitt L Rev 549 at 550: "[T]he law that governs family decision-making for the dying patient has sought, from its inception, to protect dying patients from their families."

[75] *Supra* n 1, at [8].

[76] Burt, *supra* n 52.

families making such decisions on their behalf,[77] even if those decisions may not ultimately reflect what they would have wanted.[78] This should come as no surprise. After all, many of us grow up relying on our families to make difficult decisions for us. Where we have not expressed a firm commitment for or against artificial prolongation of life, there is no reason why our families' views on how we would or should decide *must* be viewed as inimical to our best interests.

50 Neither are we immune to the effect that our decisions may have on the lives of our family members. Thus, if our continued treatment only prolongs the grief and suffering of our loved ones, this should be a factor to be considered sympathetically rather than suspiciously. Conversely, even if there is no further medical benefit to keeping us on life-support, there may be some emotional or spiritual benefit of doing so in the minds of our families. This, again, ought to be given weight.[79]

51 Under the "best interests" test, it should, however, be borne in mind that the views of the patient's family are not decisive. It must, as Choo J held, be balanced against the medical evidence. While a patient's continued living may be of comfort to a parent and could in many cases justify sustaining treatment, there may come a case such as Shiela Pouliot's where the courts may override the family's desires because continued treatment would merely exacerbate and compound the patient's physical agony and torture.

D. The role of the courts

52 There is an anterior question that cannot assumed: To what extent should the courts be involved in deciding whether to authorise the continuation or cessation of life-sustaining (or, in *Re LP*, life-saving) treatment? In accepting that the court could hear the case, Choo J has thrust the courts into an ongoing discourse about the medical treatment of incompetent patients, in particular, whether and how we should give effect to their prior wishes and critical interests even if these were opposed to what would seem a medically obvious choice. These issues make for particularly sensitive and potentially divisive debate because the personal tragedy of the patient is invariably bound up in a potent mix of

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[77] See, *In the Matter of Nancy Ellen Jobes*, 529 A 2d 434 (1987) at 446 and fn 11 (noting the results of surveys on this point.)

[78] Joanne Lynn, "Why I Don't Have a Living Will" (1991) 19 Law, Med & Health Care 101 at 101–104, cited in Lois Shepherd, *supra* n 73, at 583.

[79] Lois Shepherd, *supra* n 73, at 583–589; Burt, *supra* n 52.

culture, religion and politics that always threatens to boil over – as the unfortunate Terry Schiavo saga demonstrates.[80] Of course, the courts are no strangers to deciding issues of great social and cultural significance; constitutional law issues come to mind as just one example.

53 In *Re LP*, Choo J adopted a cautious approach. His Honour emphasised that:[81]

> Courts do not perform an oracular or purely academic function of merely declaring a particular conduct lawful or unlawful in the absence of a real dispute. … [A] court would usually only consider an application for a declaration where there is an issue between litigants. There are exceptions. In the present instance, given the patient's previous indications and the lack of support from her family, this application was a reasonable one. … [T]here were some indications that the surgery might result in litigation.

54 In other words, Choo J's opinion was that it is not necessary for the court to sanction each and every continuation or cessation of medical treatment, particularly where there is no conflict or disagreement between family members and the doctors *inter se*, as well as *inter partes*. Only in cases where there is a genuine dispute would a court enter the fray.

55 The degree of involvement that the courts should shoulder in such cases is not yet settled among the authorities in the UK, US and Australia. Ultimately, it is a question of policy. There is much to commend in a policy of minimal judicial oversight; in particular, because aggressive judicial scrutiny in every case will overburden the courts, cause needless delay in cases that are more complex and deserving of judicial attention, and increase the cost of medical healthcare. Reviewing every case in open court will also invariably cause unnecessary pain and grief to families who believe that such decisions are intensely private. In particular, as Professor Burt points out, allowing judicial review too quickly may disincentivise family members to resolve their disagreements among themselves, preferring to "tell it to the judge".[82] On the other hand,

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[80] Theresa Marie Schiavo collapsed in her home in 1990 and eventually slipped into a persistent vegetative state. Her case generated intense public and governmental attention as a result of her husband's petition to the courts to remove her gastric feeding tube in 1998. This was fiercely opposed by Terri's parents. After a string of law suits and a legislative enactment, her feeding tube was eventually removed on 18 March 2005 for the third time. She passed away shortly after.

[81] *Supra* n 1, at [6].

[82] Burt, *supra* n 52, at 440.

aggressive judicial scrutiny is welcomed by those who, quite justifiably, worry about whether the surrogate decision-makers (be it the doctors, the families or both) will make the "right" decision and whether the interests of the patient (which may or may not be consonant with her family's expectations) will be respected.[83] Indeed, even Professor Burt admits that the strong interest in allowing family members to resolve end-of-life decisions is diminished when the family opts to withhold or withdraw life-sustaining or life-saving treatment because it would not be in the service of preserving the familial relationship.[84] In my view, some level of judicial scrutiny is clearly necessary. It may be asked, for instance, why it took so long for a case like *Re LP* to reach the courts. After all, Mdm LP could not possibly be the first person in the position where a hospital has had to decide how to treat an incompetent patient. Thus, either hospitals have been acquiescing in the views of the family or *vice versa*. An assertion of judicial oversight can bring about a balance between those views and also better protect the patient's purported prior wishes, which perhaps may have been neglected thus far.

56 The answer is probably not found in the extremes. A balance must, in the end, be struck. How much more judicial scrutiny is warranted in order to prevent abuse? At what margin does the increased disadvantage of having the courts review each decision ensure that the patient's interests are protected? Choo J's proposal strikes a prudent balance. It does not involve a court hearing in every decision; neither does it involve a hands-off approach. A genuine dispute which the court can resolve is not only one where there is a "physical entity appearing as an opposing litigant"[85] but one where the facts indicate that the procedure "*might* result in litigation".[86] Therefore, as in *Re LP*, a hospital may itself bring an application on the lawfulness of ceasing or continuing medical treatment, even without active opposition from a patient's family.

57 Of course, this approach may be subject to criticism. The cynic will say that the hospital in *Re LP* brought the case to court because it was worried that if the patient recovered, she would sue the hospital for amputating her legs without her consent. Or, perhaps, her husband might

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[83] See generally, Thomas A Eaton & Edward J Larson, "Experimenting with the 'Right to Die' in the Laboratory of the States" (1991) 25 Ga L Rev 1253 at 1285–1286.

[84] Burt, *supra* n 52, at 445 and 451. He also observes that families may occasionally obstruct health care providers from applying necessary and appropriate palliative care, or conversely, compel invasive interventions when these are unable to prolong life.

[85] *Supra* n 1, at [6].

[86] *Ibid* [emphasis added].

sue on her behalf. What, then, of the cases in which the patient is without a family or where the decision is not to *save* the life of the patient but to *end* it? In these cases, what incentive is there for the hospital to report the possibility of a conflict between the patient's wishes and the hospital's medical judgment? One might also query whether we should assume that the patient's interests are assured just because there is universal agreement as to the appropriate course of medical treatment between the patient's family and the doctors.

58 These are legitimate concerns but they do not justify crippling the courts because there are better ways of resolving these issues. For one, the courts need not be the only forum in which such disputes may be tackled. Hospitals can set up specialised departments or boards that will review the decision of the attending physician, adding a layer of protection to the patient's interests.[87] This review can occur even where there is unanimity between the attending physician and the family members. One model that may be emulated is that adopted in the Advance Medical Directive Act,[88] where two medical practitioners have to confirm that the patient is terminally ill before a patient's directive is executed. If there is disagreement, the matter must be referred to a committee of specialists appointed by the Minister. Similarly, there could be a system instituted where the concurrence of two or more neutral persons is necessary before ceasing treatment. If there is disagreement – either between the family members or the doctors or the neutral persons, the matter will then be referred to a further review board. See ss 9(3) and 9(5) of the Advance Medical Directive Act. I would only caution that in the light of my earlier argument that such decisions are not purely medical in nature, the neutral persons or review board ought to comprise not only physicians but also non-medical persons. Retired judicial officers or experienced care-givers are the obvious possibilities. Another possible reform is to institute measures that would reduce the need for external intervention in the first place. For instance, it has also been suggested that mediation might be one way of encouraging the amicable resolution of conflict or disagreement between family members or between families and hospitals.[89] Such platforms may also afford families the privacy that

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[87] The emergence of hospital ethics committees or institutional review boards within public and restructured hospitals can also provide for a ready mechanism to undertake the review being proposed here.

[88] *Supra* n 35.

[89] See, for example, Diane E Hoffmann, "Mediating Life and Death Decisions" (1994) 36 Ariz L Rev 821; and also, Nancy Neveloff Dubler, "Conflict and Consensus at the End of Life" Hastings Cent Rep 2005; 35(6) Spec No: S19–25 at S23–S25. Prof Burt also feels that the role of outsiders should be confined to counselling family members

an open trial cannot. The court's role can thus be limited to an appellate one, reviewing decisions only where there is a genuine deadlock.

59 Secondly, the courts should not be the only branch of government involved in this debate. Parliament should also promulgate guidelines, in consultation with major stakeholders including the general public, on how surrogates (families and hospitals) ought to decide. Such guidelines will also tend to reduce arbitrariness and strengthen the review of decisions to cease or continue life-sustaining and life-saving treatment. In addition, the question as to when, and whether, a decision made without the sanction of the court will be immune from legal attack should be addressed. This is important because it will assure hospitals and families and prevent unnecessary litigation.[90]

60 Thirdly, Parliament should also consider legislating options that will enable presently competent persons to effectively translate their critical interests and anticipatory decisions into binding directives. By allowing persons the opportunity to make such binding decisions before they become incompetent, there will be less need for prolonged litigation, dispute and acrimony when the individual becomes incompetent. Less stress on the courts and other fora will be exerted, and they can concentrate their limited resources on patients who have never been competent or who lack any form of social or familial support. Such alternatives may take the form of an expanded advance medical directive. Currently, in Singapore, one can only affirm that one wishes to cease life-support when one is terminally ill. No other variations are contemplated. Yet, even within the confined scope of terminally illness, some conditions produce no physical pain to the patient, whereas others may. But, if pain is a serious consideration for some of us, we cannot reflect that at the moment. An expanded advance medical directive should not only be a yes-or-no checklist. It should allow for us to describe our critical interests as well so that in the event that death confronts us in an unexpected form, the proxy decision-maker will have on record our beliefs, desires, and wishes and be able to extrapolate what we would have wanted.[91] Other

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and facilitating conversation that would lead to consensus rather than having the decision vested in an outsider. Indeed, he also suggests that research has shown that the vast majority of end-of-life decisions are amicably resolved: *supra* n 52 at 439–440.

[90] See, for example, s 19 of the Advance Medical Directive Act, *supra* n 35, which immunises doctors from civil, criminal and professional liability if a decision is made in good faith and without negligence.

[91] A living will is not without problems. See Angela Fagerlin & Carl E Schneider, "Enough: The Failure of the Living Will" Hastings Cent Rep 2004; 34(2): 30–42.

options that have been mooted include providing for the appointment of a durable power of attorney or medical agents so that someone we trust will act as our surrogate if we become incompetent, again reducing conflict and tension because the patient has spoken as to whom she wants making those choices for her.[92]

V. Conclusion

61 We may summarise the foregoing discussion in two ways. First, it should be more or less obvious that at their outer reaches, the tests as to anticipatory decisions, substituted judgment and best interests converge in the sense that looking at other circumstances and evidence beyond those directly relevant to the test being applied can often assist in arriving at a just and fair and commonsensical result. Thus, for instance, an inquiry into the patient's critical interests may inform what might otherwise be construed as an ambiguous statement, which would normally fail the clear and express standard that is currently employed in assessing anticipatory decisions. Similarly, borderline subjective evidence as to the patient's critical interests can be strengthened by casting an eye toward the medical evidence. In this way, it may not be useful for the courts to adopt a strict separation of the tests but rather to appreciate that the ultimate aim of the exercise is to vindicate as best as is possible the dignitarian and autonomy concerns of the patient.[93]

However, proposals for reforming the structure and conceptual underpinnings of living wills have been made. For instance, a living will could contain different hypothetical situations and persons could record their likely responses in those contexts. Along similar lines is a system originally developed in Oregon where patients keep a record of their treatment preferences and decisions at each consultation. This would allow the decision-maker (be they the family, hospital or the courts) to assess the patient's considerations across time and circumstance: see, generally, Susan E Hickman *et al*, "Hope for the Future: Achieving the Original Intent of Advance Directives" Hastings Cent Rep 2005; 35(6) Spec No: S26–30.

[92] See generally Mark Fowler, "Appointing an Agent to Make Medical Treatment Choices" (1984) 84 Colum L Rev 985; Eaton & Larson, supra n 83, at 1295–1320. On legislative efforts, see Diane E Hoffmann, "The Maryland Healthcare Decisions Act: Achieving the Right Balance?" (1994) 53 Md L Rev 1064. In 1999, the Singapore Academy of Law published a report proposing that durable ("advance") powers of attorney be given statutory force for currently-competent persons in the event that they become incompetent. See *Civil Inquiries into Mental Incapacity: The Report of the Sub-Committee of the Law Reform Committee of the Singapore Academy of Law for the Review of Proceedings under the Mental Disorders and Treatment Act (Cap 178)* (November 1999), at pp 50–54. This suggestion has yet to be taken up by Parliament. The Mental Capacity Act 2005 (c 9) (UK) provides for the appointment of durable powers of attorney.

[93] Perhaps the only exception is a patient who was never competent; in which case, the "best interests" test should be the only test that is relevant and applicable.

62 Second, *Re LP*, being the first case of its kind to come before the courts in Singapore, was a cautious decision. Choo J preferred to restrict himself to the facts rather than create any ground-breaking law. But *Re LP* will not be the last word in this area of the law. While *Re LP* sets out a useful analytical framework for future cases, and the decision on the facts was probably correct, there is room for further refinement and exposition in such areas as to whether to accept or reject the substituted judgment test, the evidential standards that should be employed in determining whether to give effect to an anticipatory decision, the factors to be considered in the "best interests" test, and even the basic question of whether the courts should be deciding cases like *Re LP*. The work, though, should not fall solely on the Judiciary. Parliament is undoubtedly an important stakeholder; and so is the public. Hopefully, *Re LP* and its progeny will engender the sort of constructive deliberative discourse that is necessary to ensure that our own critical interests are protected should death one day come knocking on our doors.