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From Singapore

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The EAPC Ethics Task Force has done an admirable job in presenting its views on the modern debate on euthanasia and physician-assisted suicide. The paper is important and timely, as concepts change and develop following recent events and legislation which affect practice.

The paper starts with an outline of the background to the debate, followed by a good summary of the recent legislation on euthanasia and physician-assisted suicide in different parts of the world.

The section on definitions is useful and clear, with reproduction of the latest WHO definition of palliative care, followed by the excellent section stating what euthanasia is not – namely, the withholding and withdrawing of futile treatment, and the use of terminal sedation.

The first surprise in the paper comes in the definition of euthanasia, limiting it to requests for medicalized killing that are voluntary, and made by a person competent to give consent. This clarifies and sets limits to the debate. It excludes other usage of the word euthanasia, such as in the context of social engineering. It also excludes requests made by relatives to terminate the life of someone in a persistent vegetative state. Elimination of the distinction between 'active' and 'passive' euthanasia by defining all euthanasia as active is helpful.

The second interesting point is the use of the word 'killing' in the definition, as opposed to the more 'watered down' expressions of 'termination of or ending a life', although neither choice of words could be considered emotionally or politically neutral.

The Task Force takes the position against legalizing euthanasia on laudable grounds, such as for the protection of the vulnerable. It encourages debate of different viewpoints and respect for individual choices. It argues that the provision of euthanasia and physician-assisted suicide should not be within the scope and responsibility of palliative care. This is very sensible. In many cultures, patients and society are not clear on whether end-of-life care includes care to hasten, as well as ease, the end of life. One common fear of palliative care patients is that the treatment for pain or other symptoms would shorten their lives. Reassurance that this is not the case, and that euthanasia is neither allowed nor practised is necessary to achieve compliance in these patients

In Asia, there have been attempts to use palliative care to camouflage the introduction of euthanasia (both voluntary as defined in this article, and possibly involuntary as well) for economic benefits to society. Because of this, the Asia Pacific Hospice Palliative Care Network (APHN) in February 1997 stated its position publicly: 'Hospice palliative care values the individual and every moment of life. The Asia Pacific Hospice Network does not support any action which has the intention of terminating a person's life.' This was later incorporated into its Constitution, as part of a set of values accepted by its members.

In those Asian countries where religion plays a prominent part in both public and private life, there is little chance of euthanasia being legalized. As demonstrated in the public debate over the introduction of the Advance Medical Directive in Singapore in 1995, all the established religions of the region – Buddhism, Christianity, Hinduism and Islam – have clear positions against the taking of human life, which euthanasia clearly involves. They also prohibit suicide, whether physician-assisted or otherwise. Unlike in the West, where the choice of the individual is held pre-eminent, the danger in the East lies in the purely secular societies, where religious faiths take a backseat to utilitarianism, and the usefulness of an individual to society is measured by the contribution to and burden upon society. Where human life does not have an intrinsic value, these are the societies which may find it acceptable, if not desirable, to end a useless or meaningless life, destined for suffering.

How do I personally view the medical profession's fight against the seemingly unstoppable move towards euthanasia and physician-assisted suicide? First, I would oppose legislation for euthanasia, on the grounds stated by the EAPC Task Force. If it becomes inevitable, I would argue that society designate someone other than a physician, who is trained to heal, to comfort and to sustain hope in the face of hopelessness, to do the killing. If that still fails, I would fight for euthanasia to be done by physicians trained and accredited in killing, and exclude it from the scope of work of general and

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palliative care physicians. The role of the palliative care team would be to inform the patient of all his options, to stand by him in his choices, to control symptoms, and give support to the family, the same as we would for the dying patient who opts for experimental therapies in the hope of cure. But just as we need not be the experts to provide those therapies, we also do not need to be providers of the final solution.

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