2

Advance Medical Directives in Singapore: A Faltering Policy for End-of-Life Care?

TRACEY EVANS CHAN

2.1 Introduction

Advance directives rose to prominence in Singapore sometime in the mid-1990s when the National Medical Ethics Committee (NMEC) issued a report recommending enabling legislation that would recognise and give effect to individual patient decisions, made in advance of terminal illness, refusing certain forms of life sustaining treatment while the individual in question still possessed the capacity to do so. After an extensive consultative and legislative process, including deliberations by a Select Committee of Parliament, the Advance Medical Directive Act 1996 was passed and came into force on 1 July 1997. Advance directives considered in this volume encompass statements in which a competent person makes an advance *decision* in respect of healthcare, social welfare and other personal matters, which are to be implemented in the event that that person loses decision-making capacity at some later date. Pursuant to this definition, this chapter will consider the advance medical directive (AMD), which is a legislative instrument, and the common law advance decision. It then analyses reasons for the limited impact these have had on advance medical decision-making in Singapore, and observes the consequential shift to less formal and more consultative advance care planning (ACP) processes promoted by the Agency for Integrated Care in Singapore. Notwithstanding this development, it argues that there remains a legitimate role for an expanded scope of advance directives to offer a better range of options for end-of-life care to meet the needs of an evolving and diverse populace in Singapore.

https://doi.org/10.1017/9781009152631.004 Published online by Cambridge University Press

2.2 The Legal Framework: Types of Advance Directives in Singapore

2.2.1 The Advance Medical Directive

The first advance directive introduced into Singapore law is the AMD, so named to make clear that it pertained only to medical decisions.[1] The impetus for enabling legislation was the need to address difficult ethical and legal issues related to the use and withdrawal of new medical technology that eventually proved futile in preventing death. Affording a patient the ability to indicate her treatment preferences in advance would better guide her physicians in making difficult medical decisions, especially in the face of differences of opinion amongst family members. It was also recognised then that various other jurisdictions facing the very same issues had introduced and legalised advance directives to allow patients the means to be spared futile medical treatment that only prolonged the dying process, and avoid placing such decisional burdens on their families.[2]

At that time, the Singapore courts had not yet addressed the legality and operation of advance directives as a matter of common law. Waiting for a sufficient body of precedents to build up to provide sufficient legal guidance was unpredictable and would take too long. Furthermore, the reception of common law precedents from other jurisdictions may not adequately take into consideration the principles and beliefs of the local community. The NMEC therefore recommended that legislation be introduced to remedy this deficit in the legal framework pertaining to advance medical decisions.[3]

2.2.1.1 The AMDA Framework: Making an AMD

Section 3 of the Advance Medical Directive Act (AMDA) provides that anyone who is not "mentally disordered"[4] and at least 21 years of age may make an AMD in the form prescribed. In the schedule to *AMDA Regulations*, the prescribed form stipulates that the maker of a directive should not be subjected to "extraordinary life-sustaining treatment" if (a)

[1] National Medical Ethics Committee, *Advance Medical Directives* (Singapore: July 1995), p. 1.
[2] Ibid., pp. 9–10.
[3] Ibid., pp. 11–12.
[4] The previous phrase "of unsound mind" was substituted by the Mental Health (Care and Treatment) Act 2008, No. 21 of 2008, s. 33 read with the Second Schedule para. 1(1) .

the person suffers from a "terminal illness" and (b) is unconscious or incapable of exercising rational judgement. Two adult witnesses are required for a valid AMD, one of whom must be a medical practitioner (section 3(2)), and there are various disqualifications for witnesses on the bases of some interest in the estate of the person after her death, or conscientious objection to acting on an AMD (section 3(3)). It is the responsibility of the medical witness to take reasonable steps to assess the person executing an AMD and ensure that she is (a) not mentally disordered, (b) is at least 21 years of age, (c) doing so voluntarily, without undue inducement or compulsion and (d) has been informed of the nature and consequences of making an AMD.[5] Finally, the duly executed AMD must be registered with the Registrar of AMDs appointed under the Act, failing which the directive may not be acted upon (section 5).

2.2.1.2 Capacity to Make an AMD

There is some uncertainty about the capacity threshold required in order to execute an AMD. Section 3 refers to a person who is not mentally disordered. This phrase is not defined in the AMDA, but the amending legislation that introduced it, the Mental Health (Care and Treatment) Act 2008, defines mental disorder as "any mental illness or any other disorder or disability of the mind".[6] Likewise, the required medical practitioner witness is expected under section 4(a) and (d) to take reasonable steps to ensure that the patient "is not mentally disordered" and "has been informed of the nature and consequences of making the directive" respectively. The threshold of mental disorder looks like a status-based conception of capacity, for not all persons suffering from a mental disorder or disability may lack the functional capacity to make an AMD.

Section 5(1) of the Mental Capacity Act 2008 (MCA 2008) adopts a functional conception of capacity, where an incapacitated person must be unable to (a) understand the information relevant to a decision, (b) retain that information, (c) use or weigh it as part of the process of making a decision, or (d) communicate his decision. Confusingly, this latter concept of capacity appears elsewhere in the AMDA, albeit in terms reminiscent of English common law's description of functional capacity:[7] under section 10 of the Act, the medical practitioner who contemplates

[5] Advance Medical Directive Act 1996, s. 4.
[6] Mental Health (Care and Treatment) Act 2008 (note 4), s. 2.
[7] See *Re C (Adult: Refusal of Treatment)* [1994] 1 W.L.R. 290.

acting on an AMD must not have reasonable grounds to believe that "the person was not, at the time of making the directive, capable of understanding the nature and consequences of the directive". Likewise, section 19(1)(c) protects a medical practitioner from liability for a decision made in good faith and without negligence as to whether the patient was "capable of understanding the nature and consequences of the directive". There is no mention in this section of a decision as to whether a patient was mentally disordered at the same point in time, although section 19(1)(d) refers to a decision by a medical practitioner as to whether a directive was valid, which may incorporate the absence of mental disorder prescribed by section 3 of the Act.

This apparently inconsistent conception of capacity within the AMDA could be resolved in two ways: The first is that mental disorder operates as a threshold floor to making an AMD; all mentally disordered persons are precluded from making an AMD, even if they possess sufficient functional capacity to do so. The requirement for functional capacity implied by section 19(1)(c) is then an additional requirement for persons who are not mentally disordered. This interpretation is problematic. It questionably excludes persons by reason of mental disorder, whether permanent or temporary, who are nevertheless functionally capable of making an AMD, and therefore devalues their autonomy. It is submitted that mental disorder should be purposively read, instead, as a mental disorder that prevents a person from being capable of understanding the nature and consequences of making an AMD (i.e. a functional capacity requirement, by reason of a mental disorder). The NMEC in its report recommending enabling legislation did not envisage such nuanced distinctions between status based and functional capacity, but simply required that persons be legally competent to execute an AMD.[8] This interpretation would also render the capacity or competence requirement under the AMDA consistent with that which prevails more generally under the MCA 2008.[9]

2.2.1.3 Safeguards in Making an AMD

There are several provisions that protect the integrity and voluntariness of executing an AMD, which is based on the principle of respect for

[8] NMEC (note 1) p. 16, para. 2.

[9] See Mental Capacity Act 2008, ss. 4 and 5, which prescribe both clinical ("an impairment of, or a disturbance in the functioning of, the mind or brain") and functional components for the requirements of incapacity.

patient autonomy.[10] Section 14(1)(a) makes it an offence to procure or obtain the execution by another person of an AMD, by means of "any deception, fraud, mis-statement, unconscionable conduct or undue influence". It is also an offence to falsify or forge someone else's AMD, or wilfully conceal or withhold knowledge of the revocation of an AMD.[11] Curiously, there is no proscription of deception or undue influence in a patient's decision *not* to execute an AMD. This may have been an oversight, or perhaps reflects an implicit deference to the usual physician-led decision-making together with the patient's family.[12] A conviction under section 14 will deem the AMD revoked and of no effect, while in the interim, no AMD may be acted upon unless it is determined that the AMD was validly and voluntarily made in accordance with the Act.

Section 15 makes it an offence for anyone likely to have medical care of any patient from asking if that patient has made or intends to make an AMD. The underlying rationale was to address a concern that patients who signed AMDs would be neglected by doctors in their medical care. The NMEC was of the view that the medical management of a patient should not be influenced by the existence of an AMD, and so a patient should not be forced to disclose to an admitting hospital or attending physician that she has made one.[13] This seems to be an overreach as patients may not be aware of the need for and facility of an AMD. Thus, the duty or right of a medical practitioner to discuss or explore the concept of directives and the objectives and provisions of the AMDA are preserved in section 15(2) provided they are consistent with good medical practice, held in the context of a physician–patient relationship and in furtherance of the purposes of public education. Further professional ethical guidance in this respect, under the wider rubric of ACP (which may involve the execution of an AMD), was issued by the NMEC belatedly in 2010.[14]

[10] NMEC (note 1) p. 9, para. 2.
[11] Advance Medical Directive Act 1996, 2020 Rev Ed, s. 14(1)(b) and (c) respectively (AMDA).
[12] *Report of the Select Committee on the Advance Medical Directive Bill [Bill No. 40/95]*, Parl. 1 of 1996 (11 Mar 1996), para. 31.
[13] NMEC (note 1) p. 17, para. 7.
[14] NMEC, *Guide for Healthcare Professionals on the Ethical Handling of Communication in Advance Care Planning* (September 2010), para. 17, https://silo.tips/download/national-medical-ethics-committee-guide-for-healthcare-professionals-on-the-ethi.

Section 15(3) also requires that all information pertaining to a patient's making of an AMD, or communications relating to an intention to make one, must be kept confidential by the medical practitioner or other medical worker having care of the patient. This might appear to contradict the recommendation of the NMEC[15] and the Select Committee that the patient be encouraged to involve family members when making an AMD, and physician counselling and advice should extend to these family members.[16] However, section 15(3) can be read harmoniously with this expectation if the patient consents to the inclusion of family members in discussions concerning the execution of an AMD.[17] Finally, section 16 prohibits any person from making an AMD a condition for insurance or receiving medical or healthcare services.

2.2.1.4 Implementing an AMD

Terminal illness, together with incapacity,[18] is the trigger for the eventual implementation of an AMD under section 9 read with section 10. It is defined in section 2 of the AMDA as:

> an incurable condition caused by injury or disease from which there is no reasonable prospect of a temporary or permanent recovery where –
>
> (a) death would, within reasonable medical judgment, be imminent regardless of the application of extraordinary life-sustaining treatment and
> (b) the application of extraordinary life-sustaining treatment would only serve to postpone the moment of death of the patient.

Extraordinary life-sustaining treatment is defined in complementary fashion as treatment that would only postpone imminent death, but *excludes* palliative care – the provision of reasonable medical procedures to relieve pain, suffering or discomfort, and food and water.[19] One immediate implication of the use of "terminal illness" as a trigger for

[15] NMEC (note 1) p. 17, para. 5.
[16] Select Committee Report, note 12, paras. 8–9. This was also acknowledged by the Minister for Health at the Third Reading of the AMD Bill in Parliament: Sing. Parl. Reports, vol. 66(1) col. 116 (2 May 1996).
[17] See also Sing. Parl. Reports, vol. 66(1), col. 115–16 (2 May 1996), Minister for Health George Yeo.
[18] AMDA, s. 9(1)(c) describes this as being "unconscious or incapable of exercising rational judgment".
[19] AMDA, s. 2.

implementing an AMD is the exclusion of patients in a persistent vegetative state and other prolonged disorders of consciousness.[20]

There were suggestions before the Select Committee for the AMDA to define "imminent" in chronological terms, for example, within 6 to 12 months, but the committee preferred to leave this to medical judgement.[21] Instead, the Act prescribes a rigorous process to certify terminal illness. The medical practitioner responsible for the treatment of a patient ('attending physician') must first certify in the prescribed form such terminal illness in order to search the AMD register to determine if the patient has made an AMD (recall, it is unlawful under the AMDA to directly ask a patient whether he has or intends to make an AMD). The attending physician is under a duty to do so where she "has reason to believe that the person is (a) suffering from a terminal illness; (b) requires extra-ordinary life sustaining treatment; and (c) is unconscious or incapable of exercising rational judgment".[22] If the search reveals a valid AMD made by the patient that remains in force, further certification of terminal illness is required from two other medical practitioners. Out of the three certifying physicians, two of them must be specialists recognised by the Director of Medical Services (DMS) for the purposes of the Act.[23] Where the two additional certifying physicians are not in agreement, the matter has to be further referred to a separate panel of three specialists, also appointed by the DMS under section 8 of the Act. Only a unanimous opinion of this separate panel will determine the patient terminally ill under the AMDA.[24] Otherwise, the AMD will not be acted upon.

Once a person who has executed a valid AMD has been certified as terminally ill in accordance with the procedure under the Act and is not pregnant with a viable foetus,[25] it is the duty of the attending physician to act in accordance with the terms of the AMD unless there is reason to believe that (1) the patient has revoked his AMD in any recognised manner or (2) was incapable of understanding the nature and consequences of the AMD at the time of its execution.[26] Recognising that persons do change their minds about preferences for end-of-life care,

[20] Select Committee Report, note 12, para. 17.
[21] Select Committee Report, note 12, para. 36.
[22] AMDA, s. 9(1).
[23] AMDA, s. 9(3)-(4).
[24] AMDA, s. 9(5)-(7). Similar disqualifications apply to this specialist panel as apply to witnesses to the execution of an AMD: s. 9(9).
[25] AMDA, s. 10(3).
[26] AMDA, s. 10(2).

revoking an AMD is much easier than making one.[27] Section 7 allows revocation in writing, orally or by any other means of communication so long as there is at least one witness of this. The patient and the witness must notify the Registrar of AMDs as far as practicable of the fact of revocation in writing.

2.2.1.5 Consequential Provisions

In addition to imposing a duty on medical practitioners to implement an AMD once the statutory triggers have been satisfied, the Act makes several important consequential provisions. The physician who implements the AMD in good faith and without negligence shall not be subject to any civil or criminal liability, or professional disciplinary proceedings. A person acting under the instructions of such a medical practitioner is similarly protected in giving effect to an AMD unless he has knowledge of the revocation or intended revocation of the AMD in question.[28] Secondly, the implementation of a patient's AMD does not constitute a cause of that patient's death unless there was negligence in the certification of terminal illness.[29]

2.2.2 The Common Law Advance Decision

Although Singapore has adopted the model of the United Kingdom's Mental Capacity Act 2005 as its framework for handling the care and treatment of mentally incapacitated adults, it chose to omit sections 24 to 26 of that Act which deal generally with advance decisions to refuse specified treatment, which may relate to all medical treatment including the provision of artificial nutrition and hydration.[30] The drafter of the MCA 2008 chose to omit these sections presumably because the prior AMDA already deals with advance decisions in medical situations. However, because of the restrictive nature of the scope and operation of the statutory AMD, it is often asked if other advance decisions that fall outside the AMDA are legally recognised and enforceable at common law.

[27] NMEC (note 1) p. 17, para. 8.
[28] AMDA, s. 19(1) and (2) respectively.
[29] AMDA, s. 20.
[30] UK Department for Constitutional Affairs, *Mental Capacity Act 2005 Code of Practice* (London: The Stationery Office, 2007), ch. 9, para. 9.26.

Although the provisions of the AMDA do not address this issue explicitly, it seems reasonably clear that the Act is not meant to preclude advance decisions under the common law. Section 13(1) states that that Act shall not affect the right of any person to refuse medical or surgical treatment, without attempting to restrict it to contemporaneous decisions. This standing common law right to make advance decisions concerning medical treatment is well recognised.[31] In the local case of *Re LP*, the High Court recognised that "[g]enerally, a person who is sufficiently matured is entitled to give or withhold consent to any medical treatment and the doctors are entitled, if not obliged, to respect that person's decision".[32] Although the court left open the question of whether living wills or American-type advance directives distinct from an AMD were applicable here,[33] its reasoning in authorising the amputation of the patient's gangrenous legs held that the patient's *earlier* statements to her doctors did not amount to a clear, express refusal of treatment presently proposed.[34] This appears to be an implicit endorsement of the right of a patient to refuse treatment in advance at common law. Furthermore, the NMEC's proposals to legislate on AMDs made clear that the intention in doing so was to provide a clear and certain legislative route, while allowing for the continued development of ethical principles and common law in relation to advance directives and related issues.[35]

Therefore, patients dissatisfied with the limited ambit of the statutory instrument could have recourse to a common law advance directive.[36] There are no prescribed formalities for this, although the common law places the burden on anyone seeking to rely on the terms of an advance decision to satisfactorily prove its existence and validity. However, where

[31] *Re T (Adult: Refusal of Treatment)* [1992] 4 All E.R. 649 (C.A.); *Hunter and New England Area Health Service v A* [2009] NSWSC 761.

[32] *Re LP (Adult Patient: Medical Treatment)* [2006] 2 S.L.R.(R) 13, [4].

[33] The court did not specify exactly how these American-type advance directives differ from an AMD, but advance directives in the United States encompass both living wills and durable powers of attorney. The former can be broader in ambit, covering both terminal illness and permanent unconsciousness, and other types of treatment apart from life-sustaining treatment: see American Cancer Society, "Types of Advance Directives", www.cancer.org/treatment/finding-and-paying-for-treatment/understanding-financial-and-legal-matters/advance-directives/types-of-advance-health-care-directives.html.

[34] [2006] 2 S.L.R.(R) 13, [8] and [11].

[35] NMEC (note 1) p. 13, para. 10.

[36] The same view was taken soon after the AMDA came into force: K.L. Ter and S. Leong, "Advance Medical Directives in Singapore" (1997) 5 *Medical Law Review* 63, 83.

life is at stake, "clear and convincing" proof is required of its existence and continuing validity.[37] The ethical guidance from the Singapore Medical Council on end-of-life care stipulates that a patient's wishes not to receive specific treatments must be respected,[38] while its *Handbook on Medical Ethics* states that, apart from an AMD, "any advance statement made by patients on care or treatment that they might accept or refuse in particular circumstances" is helpful in determining a patient's values, concerns, wishes, and ultimately what is in their best interests.[39] Although the SMC's *Handbook on Medical Ethics* pronouncements are more likely intended to assist in the determination of a patient's overall best interests under the MCA,[40] the NMEC envisaged that discussions on ACP could lead to the drafting of an advance directive.[41] In particular, the committee described advance directives in broader terms than an AMD, encompassing "oral and/or written instructions that convey treatment preferences in the event of a loss of decision-making capacity".[42]

However, this flexibility of form gives rise to potential evidentiary and interpretational uncertainties concerning the implementation of a common law advance decision. For example, there is no independent witness requirement at common law, and there is no equivalent statutory protection against civil or criminal liability or professional disciplinary proceedings in determining the validity of a common law directive. This may impede the respect for and implementation of such advance decisions. Unlike the AMD, there is also no statutory registration mechanism that might provide assurance that the terms of a written common law directive will be brought to the attention of attending physicians in the

[37] *HE* v. *A Hospital NHS Trust* [2003] 2 F.L.R. 408 (EWHC).

[38] Singapore Medical Council, *Ethical Code and Ethical Guidelines* (2016), p. 20, part A7, para. 3.

[39] Singapore Medical Council, *Handbook on Medical Ethics* (2016), p. 11 (where "best interests" is confusingly stated to be representative of their right to autonomy) and p. 30.

[40] MCA, s. 6(7)(a) requires a doctor determining a patient's best interests to consider the latter's past and present wishes and feelings, and in particular any relevant written statement made by the patient when she had capacity.

[41] See NMEC, note 14, para. 17.

[42] Ibid., para. 12. It is unclear to what extent the medical profession in Singapore appreciates the legality and potential of common law advance directives, although they have been recognised by some: A. Devanand, "Guide to End-of-Life Decision Making", (July 2015) *SMA News* 36–7, www.sma.org.sg/UploadedImg/files/Publications%20-%20SMA%20News/4707/Professionalism.pdf.

appropriate circumstances – but access to the AMD registry is an unwieldy process to begin with.[43]

The *Specific Licensing Terms and Conditions on Medical Records for Healthcare Institutions* instead requires that a patient's medical record include documents pertaining to her advance care plan if prepared.[44] As ACP may result in the documentation of an advance decision to accept or refuse medical treatment, which could arguably amount to a valid common law directive,[45] this must therefore be captured in the medical record as well. The National ACP Steering Committee and Agency for Integrated Care have also rolled out an ACP information technology system that captures key decisions on care options, and catalogues conversation transcripts and other supporting documents into a single record. Since April 2017, this system has been integrated with the National Electronic Health Record (NEHR), thus enhancing accessibility and availability across different institutional care settings.[46] It therefore becomes more likely that any common law advance directives made by a patient in the process of ACP will be brought to the attention of attending physicians throughout the public healthcare system with access to the NEHR. Nevertheless, under the Living Matters ACP initiative, the emphasis has been to deemphasise the completion of legal directives and promote iterative conversations and regular opportunities to review care plans to adapt to changing health and care circumstances.[47] There nonetheless seems to be less concern that any documentation on end-of-life planning will adversely influence the clinical care of the patient. In any case, the proscription on enquiring about the existence of an AMD does not apply to such instruments.

However, unless there is some standardisation of the language and intent behind such common law advance directives, uncertainties as to interpretation and circumstances of implementation will remain. In this

[43] See note 22 and accompanying text.

[44] Ministry of Health, *Specific Licensing Terms and Conditions on Medical Records for Healthcare Institutions Imposed under s. 6(5) of the Private Hospitals and Medical Clinics Act* (6 August 2015), para. 4.2(j).

[45] S. Menon, "Advance Decision-Making in Singapore", in J. Chin et al. (eds.), *Caring for Older People in an Ageing Society*. Vol. 2 of *A Singapore Bioethics Casebook:* (Singapore: National University of Singapore, 2017), www.bioethicscasebook.sg.

[46] See I. Chung, "Advance Care Planning in an Asian Country", in K. Thomas et al., *Advance Care Planning in End of Life Care*, 2nd ed. (Oxford University Press, 2018), ch. 23, 327–8.

[47] Ibid., p. 332.

respect, individual healthcare institutions are in the process of developing and implementing policies on how ACP documents are recorded and implemented.[48] ACP documents preferences and values on types of treatment depending on the stage of illness. Some of these preferences may be stated in directive terms, such as "DO NOT attempt CPR [cardiopulmonary resuscitation]",[49] or indications that proxy decision-makers are to strictly follow the patient's wishes.[50] On the other hand, the terms advance directive or decision are eschewed, and standard forms begin with the overarching statement that physicians "will always act in the patient's best interests. . .".[51] This reference perhaps alludes to the best interests standard of proxy decision-making in the MCA 2008, where prior statements of wishes and feelings are to be considered but have no binding authority.[52] This leaves some uncertainty about whether ACP documented preferences and wishes that are sufficiently precise and directive will be treated as having the binding effect of a common law directive. Nevertheless, the uncertainties in interpretation and confidence in implementation by healthcare professionals that originally concerned the NMEC in its 1995 report appear, to some extent, to have been addressed by the development of ACP policies, documents and protocols at the institutional level. Information technology has also afforded the means to overcome barriers to access for common law advance directives that are produced as a result of ACP. What is needed is clearer professional guidance on the recognition and implementation of common law advance directives, otherwise any documented preferences may simply be overridden by professional medical judgement of the patient's best interests or family objection on similar grounds.

2.3 Assessing the Impact of Advance Directives in Singapore

If we look at absolute numbers, the take-up of AMDs in Singapore has thus far been very low. The Registry of AMDs does not publish statistics on AMD registrations and implementation, although the public is given periodic updates in the form of answers to questions filed in Parliament

[48] See Menon, note 45.
[49] See T.E. Chan, "Advance Care Planning: A Communitarian Approach?" (2019) 26(4) *Journal of Law & Medicine* 896, Appendix 2 – Preferred Care Plan, para. A.
[50] Ibid., Appendix 1 – Disease Specific Advance Care Plan (General), para. H.
[51] Ibid., Appendix 1 and 2.
[52] MCA 2008, s. 6(7)(a).

on AMDs. Between 1997 and 2008, a total of 10,100 AMDs were registered representing 0.4% of the resident population (three quarters of those between 2004–8), 19 were revoked and six were implemented.[53] By 2015, the last recorded disclosure on AMD statistics, 24,682 AMDs were registered and 10 AMDs were implemented, representing 0.7% of the resident population.[54] There are no apparent data on or research looking at common law advance directives, although in the parliamentary response in 2016 just mentioned, it was revealed that about 5,100 advance care plans had been completed between 2011 and 2015.

These numbers should not be surprising given the very restrictive ambit and formalities of the AMD. As mentioned previously, patients in a persistent vegetative state or other prolonged disorders of consciousness cannot depend on an AMD to refuse such treatment. Imminent death, as part of this definition, is also not defined in chronological terms but left to medical specialists to determine.[55] However, studies elsewhere and in Singapore reveal that it is very difficult to make a definitive prognosis of death even when it is very close.[56] Thus consensus between the required two or three medical practitioners certifying terminal illness will be less frequent. Extraordinary life-sustaining treatment hinges on terminal illness in order to be considered as merely prolonging the dying process. It further excludes palliative care, which includes the reasonable provision of food and water without specifying the means – commentators assume this exclusion will cover the reasonable provision of artificial nutrition and hydration.[57]

The sum effect of these restrictions means that AMDs only cover situations of undeniable medical futility, for which the existence of an AMD adds little deliberative value to the decision to withdraw life-sustaining treatment.[58] Thus, local medical practitioners familiar with its terms have observed that there was no practical point in executing an

[53] Sing. Parl. Debates, vol. 85(1) col. 695 (17 November 2008), Minister Khaw – Oral Answers to Questions: Advance Medical Directive.

[54] Sing. Parl. Debates, vol. 94(21) (11 July 2016), Minister Gan – Written Answers to Questions: Number of Singaporeans Who Have Signed Advance Medical Directives.

[55] NMEC (note 1), p. 14; Select Committee Report, note 12, para. 36.

[56] J. Lynn, "Living Long in Fragile Health: The New Demographics Shape End of Life Care" (2005) 35(6) *Hastings Center Special Report* S14;J. Tan and J. Chin, *What Doctors Say about Care of the Dying* (Singapore: Lien Foundation, 2011), p. 3, www.lienfoundation.org/sites/default/files/What_Doctors_Say_About_Care_of_the_Dying_0.pdf.

[57] See Ter and Leong, note 36, p. 74.

[58] A.E. Buchanan and D.W. Brock, *Deciding for Others: The Ethics of Surrogate Decision Making* (Cambridge University Press, 1989), 296–7, discussing the California *Natural*

AMD.[59] Part of the reason for this overly cautious legislative approach might have been the prevailing health policy zeitgeist at the time the idea of advance directives was first mooted by the NMEC in its position paper in August 1994.[60] This was not long after the Singapore Government had promulgated its White Paper on *Affordable Health Care*,[61] which emphasised cost containment and sustainability in healthcare expenditure, along with individual responsibility for one's health and to avoid over-reliance on state welfare or medical insurance. This juxtaposition, along with the common misunderstanding that AMDs were a form of passive euthanasia because they involve the withdrawal of treatment leading to death,[62] may explain public concerns over neglect by medical practitioners once a patient had signed an AMD[63] or that the underlying motivation for recommending an AMD was healthcare cost containment.[64] These concerns led to stifling restrictions like making it a criminal offence for any doctor to ask if a patient had executed, or intended to execute, an AMD, thus making it that much harder for them to broach the issue as a legitimate part of end-of-life care. The NMEC has since clarified the ethics of communications in ACP, which may include the execution of an AMD or common law directive, thus providing a clearer path for physicians to raise these issues in clinical practice and, correspondingly, questioning the further need for such restrictions.[65]

Even if the AMD were not so restrictive, it is questionable if patient responses would have been markedly different. Health decision-making practices in Singapore tend to adopt family-centric decision-making models that run counter to the individualistic, transactional model that the AMD is based on. Under the former model, many patients prefer to leave decision-making to trusted family members, and do not see it as their responsibility to make decisions, much less execute an advance

Death Act (1976); Cal. Health & Safety Code, §7187(f) (1976), on which the definition of "terminal illness" in the AMDA is adapted: see NMEC (note 1) p. 14, para. 3.

[59] See Tan and Chin, note 56, p. 41.

[60] See Section 2.2.1.3 for the details of these statutory safeguards.

[61] Ministry of Health, *Affordable Health Care: A White Paper*, Cmd. 16 of 1993; advance directives were first mentioned in Parliament in connection with this White Paper: K.H. Tee et al., "Advance Directive: A Study on the Knowledge and Attitudes among General Practitioners in Singapore" (1997) 38(4) *Singapore Medical Journal* 145.

[62] See Tee et al., ibid., p. 147; see also Sing. Parl. Debates, vol. 65(4) col. 355, Health Minister George Yeo.

[63] See Health Minister George Yeo, ibid., col. 356; Health Minister Khaw, note 53.

[64] See Ter and Leong, note 36, p. 65.

[65] NMEC Guide, note 14; AMDA, s. 15(2) respectively.

directive.[66] An additional challenge is the not uncommon practice of collusion between families and physicians to withhold diagnosis and poor prognosis from a vulnerable patient, which also prevents active participation and independent decision-making.[67] Amidst such practices, the need and ability to exercise individual moral authority to take responsibility for one's healthcare decisions do not arise at all. Others argue that in such a familial model of decision-making, advance directives are means of helping family members understand the patient's voice in order to arrive at a family decision, which should not be dictated by the literal meaning of the advance directive.[68] Therefore it is not necessary in this thinking to institutionalise individualistic expression of prior wishes strictly by laws and regulation.

Finally, even if we were to put aside cultural values and practices, human psychology imposes various challenges in making good anticipatory decisions about future health scenarios with incomplete information. The literature raises doubts about people's ability to accurately anticipate their reactions to serious illness, the stability of their life-sustaining treatment preferences even over short periods of up to two years (at least for a substantial minority) and their tendency to overestimate the stability of their attitudes and beliefs over time.[69] More recent psychological research on affective forecasting has led to better understanding of the systematic biases at play in making predictions about future preferences, apart from a lack of information about the future. One example is impact bias, which tends to predict greater intensity and longer lasting effects of future events than is actually the case. This is a result of the overweight of focus on the event itself, to the exclusion of the contribution of other factors to the predicted outcomes. Secondly, we also tend to underestimate our ability to adapt to negative events and habituate to positive ones.[70] As a result, individuals will often mis-predict

[66] See e.g. Tan and Chin, note 56, p. 12; K. Tay et al., "Cultural Influences upon Advance Care Planning in a Family-centric Society" (2017) 15 *Palliative & Supportive Care* 665.

[67] See Tan and Chin, note 56, pp. 13–5; S. Menon et al., "Some Unresolved Ethical Challenges in Healthcare Decision-Making: Navigating Family Involvement" (2020) 12 *Asian Bioethics Review* 27, 29.

[68] H.M. Chan, "Sharing Death and Dying: Advance Directives, Autonomy and the Family" (2004) 18(2) *Bioethics* 87, 96–7.

[69] P.H. Ditto et al., "Imagining the End of Life: On the Psychology of Advance Medical Decision Making" (2005) 29(4) *Motivation and Emotion* 475, 486–88; in respect of the last finding, see also J. Quoibach et al., "The End of History Illusion" (2013) 339 *Science* 96.

[70] Ditto et al., ibid., pp. 488–9.

their future preferences, and weigh relevant considerations differently depending on how far in the future a present decision is meant to apply. There is some correspondence between these findings and qualitative studies looking at the reasons why individuals do not see advance directives as useful,[71] and in the experience with ACP and patient preferences in Singapore.[72]

If we combine these insights based on history, culture, typical preferences for methods of medical decision-making and human psychology, we should question whether continued promotion of advance directives by improving the legal and supportive healthcare framework is the best way forward. Although there were discussions about amending the AMDA circa 2008, nothing came to bear on this.[73] Instead, in 2009, ACP was piloted in a Singapore tertiary hospital and subsequently scaled up to a national programme, "Living Matters".[74] This approach to advance healthcare decision-making seeks to emphasise a relational, patient-centred process supported by trained healthcare professionals and trusted family members. It seeks to move away from the earlier, legally focussed, transactional process[75] towards a more open, inclusive and iterative communications process directed towards the same goal of enabling patients to retain control over their care once they lose decision-making capacity.[76] Ideally, when properly engaged, ACP will prepare patients and their proxy decision makers to make better in-the-moment medical decisions with their physicians on the basis of these communications, instead of advance decisions with incomplete information.[77]

[71] See M. Spranzi and V. Fournier, "The Near-Failure of Advance Directives: Why They Should Not Be Abandoned Altogether, but Their Role Radically Reconsidered" (2016) 19 *Medicine, Health Care and Philosophy* 563.

[72] See Chung, note 46.

[73] See Health Minister Khaw, note 53; in particular, it was mentioned that the AMDA should be amended to simplify the process and do away with the requirement for a medical practitioner witness, and also remove restrictions on healthcare professionals raising the issue of executing an AMD with patients.

[74] See Chung, note 46, pp. 326–7. For a more detailed discussion of the issues related to ACP and Living Matters in Singapore, see Chan, note 49, pp. 897–8.

[75] T.J. Prendergast, "Advance Care Planning: Pitfalls, Progress, Promise" (2001) 29(Supp 2) *Critical Care Medicine* N34, N37–38.

[76] S.E. Hickman et al., "Hope for the Future: Achieving the Original Intent of Advance Directives" (2005) 35(6) *Hastings Center Report* S26, S30.

[77] R.L. Sudore and T.R. Fried, "Redefining the 'Planning' in Advance Care Planning: Preparing for End-of-Life Decision Making" (2010) 153(4) *Annals of Internal Medicine 256; see NMEC, Guide for Communication in ACP*, note 14, para. 16; see Chung, note 46, p. 330.

Even so, there will still be room for more flexible advance directives. Some patients have firmer preferences for end-of-life care, particularly when disease trajectories are relatively more predictable.[78] Family and social bonds may also be diminishing, with an increasing proportion of single adults and married persons without children.[79] This may result in a lack of adequate social support for effective proxy healthcare decision-making pursuant to an ACP programme. Differing social contexts suggest that the ACP model of decision-making may not suit all patients, some of whom may want more reliable means of ensuring respect for personal preferences in healthcare in the absence of trusted and willing proxy decision-makers. Studies elsewhere have revealed the existence of a stable minority of patients who want to retain control through the use of advance directives,[80] and the more informal ACP framework will need to be augmented to accommodate their preferred model of ACP.[81]

2.4 Conclusion

In summary, while Singapore was out of the gates very early as far as advance directives are concerned, AMDs have never really taken off in ACP and healthcare decision-making. For reasons that have to do with the social and policy climate at the time they were first introduced, prevailing cultural values and familial approaches to healthcare decision-making, and limitations on anticipatory decision-making in human psychology, the AMD initiative to jump start better respect for patient autonomy at the end of life has faltered. The current preferred Living Matters ACP programme seeks to learn from and avoid the difficulties experienced with AMDs, but it is argued that there remains a legitimate role for more flexible advance directives as the values, needs and expectations of the Singapore populace evolve.[82]

[78] See M. Ho et al., "The Physician-Patient Relationship in Treatment Decision Making at the End of Life: A Pilot Study of Cancer Patients in a Southeast Asian Society" (2013) 11 *Palliative & Supportive Care* 13.

[79] National Talent and Population Division, Prime Minister's Office, *Population in Brief 2020* (Singapore: September 2020); www.strategygroup.gov.sg/files/media-centre/publications/population-in-brief-2020.pdf.

[80] See Spranzi and Fournier, note 71, pp. 565–6.

[81] For more detailed discussion on this, see Chan, note 49, pp. 911–12.

[82] See Tay et al., note 66, p. 672.