



MINISTRY OF HEALTH
SINGAPORE

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**SPEECH BY MR KHAW BOON WAN, MINISTER FOR HEALTH
AT THE OPENING OF LIEN CENTRE FOR PALLIATIVE CARE
ON 14 OCTOBER 2008 AT 11.30AM, AT LECTURE HALL, LEVEL 4,
NATIONAL CANCER CENTRE**

“ENSURING A GOOD DEATH”

1 In the past 4 weeks, I met many Health Ministers in Manila, first for the WHO Western Pacific Regional Meeting and then again for the ASEAN+3 Health Ministers' Meeting. Over informal meals, we discussed our common problems and the standard of healthcare in our countries. Many complimented us on the quality of our healthcare services, having visited our hospitals in the public and private sectors. Some had actual experience to share as we treat quite a number of their patients here.

2 I quietly agreed that we can be proud of our care for the acutely ill. We offer First World standard of care, at a fraction of the cost in the west. That is why we attract a growing number of foreign patients who seek treatment here for cancer, heart disease, ophthalmology and general surgery.

3 But our performance is not perfect. While I think we deserve at least an A- for acute care, I can only score a C for our care of chronic diseases. Too many Singaporeans are still ignorant of their chronic diseases; fewer still come forward to have their chronic diseases managed regularly and treated consistently. As a result, too many end up with unnecessary complications requiring intensive acute care. Every day, a diabetic has a foot or toe amputated. We are fixing this problem and working with GPs and hospitals to get more patients to screen for the major chronic diseases and to follow up with their care. We have roped in 700 GPs to help manage diabetes, high blood pressure, lipid disorder, stroke, COPD and asthma. We have allowed the use of Medisave to help pay for the treatment. We are making some progress. But there is still much to do, both for these chronic diseases, as well as others, such as mental illness. Let's aim to move our score up to B as the next target.

Care for the dying

4 However, in the care of the dying, we are underperforming. We have not done as well as say, Australia or UK. “Why is this so?” you might ask.

5 Past history has something to do with it. MOH has been hesitant in supporting this cause. Its institutional memory has been coloured by that of the Sago Lane death houses, where the dying spent their last months in misery and neglect. The care of the dying became assigned, by default, to a couple of VWOs and the kind-hearted souls running them. In the 80's, hospice care started in St Joseph's Home on the suggestion of the late Dr Ee Peng Liang. Dr Anne Merriman of NUS started home hospices with a group of volunteers at the Singapore Cancer Society. Her effort eventually led to the formation of the Hospice Care Association. There were other pioneering efforts such as the establishment of the Dover Park Hospice by Dr Seet Ai Mee and Dr Jerry Lim.

6 Then in the 90's, Dr Francis Jayaratnam, as Head of Geriatrics in TTSH, sent many doctors overseas for training in palliative care, ensuring that we now have a pool of trained people in this area. Thanks to the foresight and tenacity of these pioneers, we now have several hospices and palliative care is provided in almost all public hospitals. Fortunately, the limited support from MOH has not been disastrous, as our population is still young. But we cannot stay young forever. We therefore need to ramp up our support, both to cope with the continued ageing of our population as well as to exploit the advances in medical science on the care of the dying. We can now do much more to raise the quality of life of the dying, to ease their pain, to preserve their dignity and to support their care. With empathy, listening and compassion, we can make a real difference to the lives of people in the throes of their final illness and to the lives of their loved ones. The alternative is either neglect at home or costly futile care in the wrong setting, tethered to machines, at great pain and discomfort to the patients. Both are bad options which we won't wish on ourselves or our loved ones.

Good death

7 Although everyone may have a different idea about what would constitute a "good death", for many this would involve being treated with dignity and respect, without pain, in familiar surroundings and in the company of loved ones. Some terminally ill do experience excellent care in hospices, care homes and at home. But some experience unnecessary pain and many do not die where they would choose to.

8 We are rectifying these limitations. First, MOH now recognises the useful role played by hospices and subsidises it for the needy. Last year, 4,400 patients benefited from subsidised inpatient hospice and home hospice services. As our population grows older, and as awareness of end-of-life issues increases, we will support the further expansion of hospice care in the community.

9 Second, we now recognise palliative medicine as a medical subspecialty and are training more doctors and nurses in this subspecialty. There is now a structure for training and accreditation. I am encouraged to note that some young doctors have opted to do the Master of Medicine in Family Medicine with a view to subspecializing in Palliative Medicine. Similarly, work is under way in Nanyang Poly to review the Advanced Diploma in Palliative Care for nurses. We will encourage more young nurses, especially those working in the long term care sector to take up Palliative Care.

10 Third, we are piloting a scheme to bring end-of-life planning into our nursing homes. This aims to provide nursing home residents with a holistic care plan that fully respects their wishes for end-of-life care. This will be done sensitively as discussion on death is never easy. But leaving this important subject unsaid will only promote uncertainty surrounding the issues that every one must eventually face. We are working with the palliative care community to develop a set of guidelines for our healthcare professionals on advance care planning, providing patients and their family with information on the options of care, and helping to incorporate their wishes into future treatment plans.

11 Fourth, we have decided to promote the Advance Medical Directive (AMD) actively. AMD came into effect in 1997, 11 years ago. It empowers the terminally ill and preserves self-determination into the period in which the patient is unconscious or incapable of exercising rational judgement. This is important because many of the decisions towards end-of-life will depend on an individual's view of how the treatment may meet his personal goals. Today, fewer than 10,000 Singaporeans have an AMD, a rather low uptake. We have been too cautious and unduly squeamish in promoting the AMD. But timely discussion and planning about the dying process should be an integral part of holistic care of any patient whose death is imminent. This process helps the patient's wishes to be respected in a dignified, humane way. In the US, UK and Canada, they have found that when done well, the patient and loved ones are more confident when confronting end-of-life issues and death.

12 We will simplify the process of making an AMD by providing a multilingual registration form with plain language and clearer FAQs so that the public can understand it better. It is not only the public who are confused. Some doctors have told us that they shy away from acting as witnesses for AMDs because they themselves do not fully understand the implications of the AMD. We must address this.

13 Fifth, we should extend palliative care to also address the needs of the people around the dying person. The suffering is not only confined to the dying person, but the loved ones who have got to pick up the pieces. Geriatricians have often reported cases where the relatives become ill themselves from profound bereavement and grief. This area of palliative care is even more wanting and challenging.

More "die-logues"

14 Underlying these initiatives is the need for us to have more "die-logues" about death, and not sweep it under the carpet. This is a term I first heard from Mr Gerard Ee when he wrote to me on behalf of the Lien Foundation, asking for more "die-logues". I agree with him that we need to overcome taboos about death and communicate better, both among ourselves as well as between doctors and their patients. We will work with partners such as our palliative care community of doctors, nurses, allied health professionals and volunteers to promote more "die-logues".

15 ZB in recent weeks published a number of letters from its readers on the topic of euthanasia. They were written with passion and from actual experience, both as patients and carers. I am particularly moved by the account of one reader (ZB, Oct 3) whose parents in their late 80's have for years been completely bed-

ridden after suffering from stroke. She described them as merely “san-deng citizens”: “deng-chi; deng-shui; deng-si” (“三等公民，‘等吃’，‘等睡’，‘等死’”). She vowed not to become a “san-deng citizen” like her parents and instructed her children that should she suffer a stroke in the future resulting in a completely bed-ridden incapacitated state, “please do not save me; I would rather die than to suffer being alive”(“千万不要救我，我宁愿死也不愿活受罪”). She hoped that her letter would lead to more discussion on the dying process and help society shape its attitude towards issues like euthanasia.

16 I do not know if Singaporeans are ready for euthanasia. But I do know that ageing will throw up many more human stories of agony and suffering. Obviously, properly cared for, many sick and disabled people can live worthwhile lives. But for some, long terminal illnesses can be horrific, even in spite of good hospice care. Many will take a slow and inexorable journey towards death. Western society is beginning to realise the implications of their living so much longer. The same demographic changes are coming to us in Singapore too. All societies will have to prepare for longer life spans and the many dilemmas that they will have to confront. We must seek a humane way out of such dilemmas.

17 To do our job properly, we need to fill in the gaps in knowledge and increase our understanding of the preferences of the dying in Singapore. I therefore welcome the setting up of the Lien Centre of Palliative Care at Duke-NUS Graduate Medical School. I hope your research will deepen our understanding of the needs and cultural differences between the ethnic communities in Singapore. We welcome your deeper insights into the needs and wants of the terminally ill here. This will help set standards in care for the dying and provide a foundation for the development of advanced care planning guidelines. It is my hope that the Lien Centre will, in due course, develop into a regional institute for Palliative Care Research and Training.

Getting it right

18 To the Lien Foundation, we thank you for your generous donation. Your kind contribution will go some way to assist Singaporeans and healthcare professionals alike to confront both the certainty and uncertainties of death. After all, getting end-of-life care right lies at the heart of what it means to be a civilised society. Society should make this a priority.

19 It is interesting that while death is the only certainty in life, many people do not think about what they want to accomplish before the end comes and how they want to depart this life. I suppose many just drift through life and do not plan ahead. I hope the Lien Centre will help more to stop drifting and start planning.

Thank you.
