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# FIELDNOTES OF A PSYCHIATRIST

CHONG SIOW ANN

Straits Times Press

## PREFACE

I have often been asked all sort of questions about my profession and what it's like to be a psychiatrist; in some way that curiosity of others prompted my first piece for The Straits Times which was a reflection of my chosen vocation and the motivations that drive us to be practitioners in what has been described by one of the luminaries of our profession as "the most humanistic discipline within medicine".

The second article I wrote was in the aftermath of my patient's suicide; the writing of which was a form of catharsis and a way of processing that mess of feelings that I had been carrying inside me for quite a while – there's no denying that there was something self-serving in that therapeutic release of confessional expression.

And that self-indulgence, I was comforted to know, seems to be a part of what makes one wants to write. "I write entirely to find out what I'm thinking, what I'm looking at, what I see and what it means. What I want and what I fear," admits Joan Didion, and that's certainly the case with me when writing these opinion pieces.

When Chua Mui Hoong, the Opinion editor, asked if I would like to be on the panel of expert contributors to the By Invitation column, it was, of course, something that I couldn't possibly resist, so my greatest debt is to her for getting me started and giving me that literary pleasure of communicating on a regular basis with a wider community.

The pieces assembled here have been selected from the lot that I have written in the past few years, and I have grouped them around

some common threads, and not by chronology. These themes include our troubled attitudes towards dying and death; the conundrums of medicine and psychiatry that can be personal, tumultuous and dramatic; and of our attempts to live in a meaningful way in the messiness of life.

Some are stories about individuals, their struggles and their valiant resilience. Most of the pieces which are more descriptive than prescriptive tried to give an idea of what it's like to care for a dying parent, to parent a challenging child, to lose a child, to be mentally ill, to navigate as a patient the healthcare system with all its striving and shortcomings, and what it's like to practise medicine in all its uncertainty and glory.

These were newspaper columns that came with an imposed word limit and hence getting across the more nuanced arguments and qualifications can be difficult. But in putting together this collection, I had the opportunity to look at all of them once again and to see which could pass muster in the rereading; and of those selected, I have amended many – either rewriting, omitting and/or adding to freshen them up.

In the list of sources, I have as far as possible credited the ideas and influences for each piece. I drew much from a pantheon of writers including physician-writers like Oliver Sacks, Atul Gawande, Jerome Groopman and Sherwin B. Nuland; I have tried (though I do not know how successfully) not to slip into the genre of the cento i.e. a piece constructed largely of quotations.

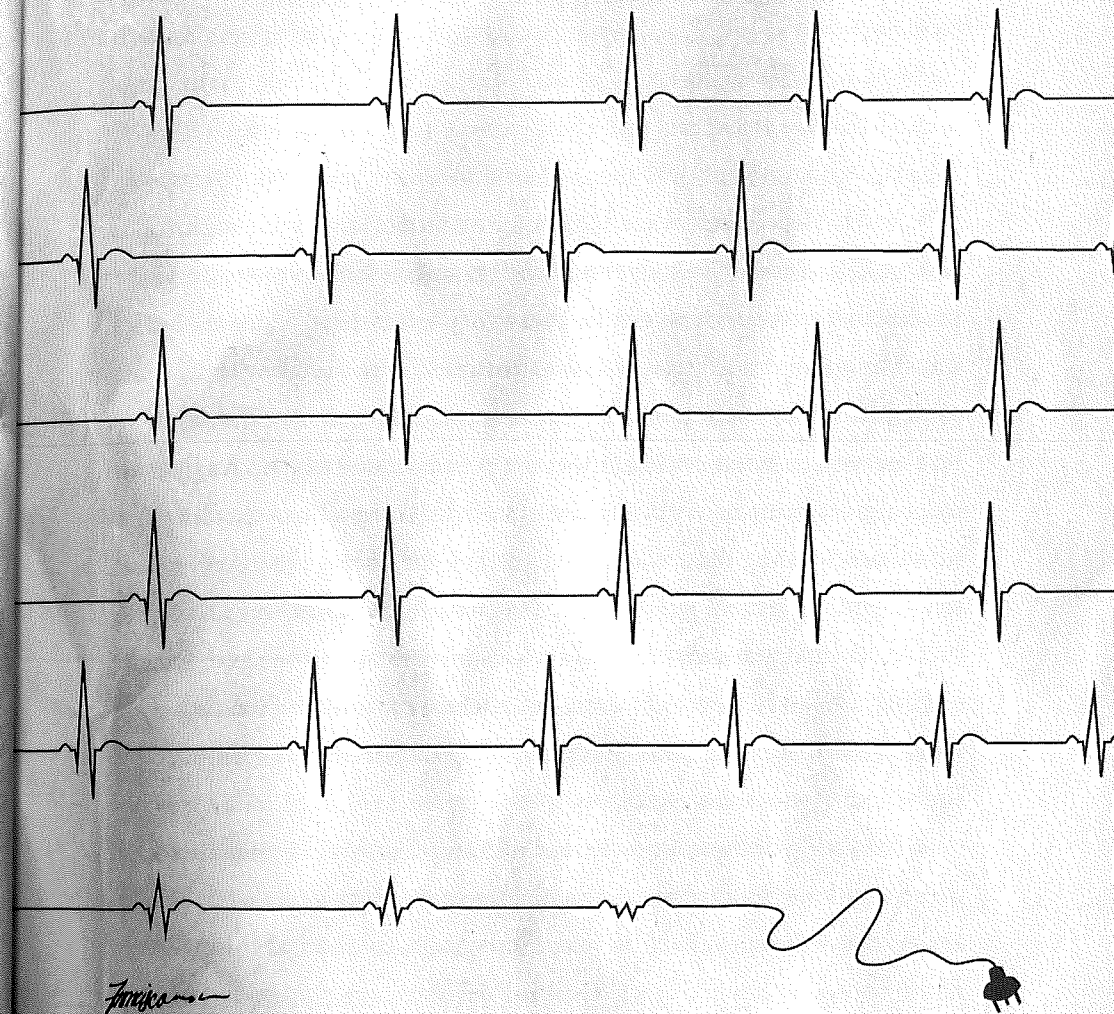
A number of my patients and their families have kindly let me use their lived experiences and stories, but it is somewhat ironical that I have not used their actual names as stigma is one of themes of some of the pieces here, and it ought to be the case of not playing up to that stigma to hide their identities. But I do fear for them as much as they are fearful of revealing the presence of mental health issues in their lives, and that speaks volumes of how far we have to go in being that inclusive society

that we have professed to want. I hope the pieces here will make the readers think harder and reconsider some of their intuitive beliefs and preconceived notions – just as I have in the writing of them.

I am grateful to Mui Hoong, Lydia Lim and Audrey Quek, generous editors of the Opinion section in The Straits Times, for giving me a free rein to write what I'd wanted and for making me feel what E.B. White had once described an essayist to be – “a self-liberated man, sustained by that childish belief that everything he thinks about, everything that happens to him, is of general interest”; and I'm deeply grateful to all those people in my life who have inspired and helped me and who have given these pieces their substance, shape, form and tenor.

PART ONE

# DYING, DEATH



*Frickman*

## THE DAY I WANTED MY FATHER TO DIE

Shortly after World War II ended, my father joined the multitudes of Chinese in the exodus from their country of birth to seek a better life for themselves and to enable those they left behind to have a better life. His passage to Singapore was arranged by an uncle who was the principal of a Chinese school here and wanted his help in running it.

Possessing the equivalent of a high school education, he was put to work almost immediately by the uncle, initially doing a bit of teaching and subsequently doing the accounts and keeping the books. He stayed in that school until he retired. In that time, he married and fathered five children.

One day every month, he would send money to his mother and siblings in China. With his modest salary, and the responsibility of looking after two families, my father was necessarily frugal. But he allowed himself a single indulgence - his cigarettes.

Reserved by nature, he was also restrained in his expression of any overt emotion. His love for us was shown rather than verbalised. When any of the children fell ill, he would keep a bedside vigil through the night: sponging down a fever, soothing us.

In my first year of secondary school, he would turn up every evening at my school. He would commandeer my school bag and slip the strap on his shoulder as we made our way to the bus stop. Trudging alongside him and resentful with embarrassment, I would keep my eyes firmly on the

ground to avoid whatever derision and sniggers I imagined might come from my schoolmates, and shoved my fists in my pockets to prevent him from taking my hand.

When he was in his 60s, he developed chronic obstructive pulmonary disease, probably from his years of smoking. The illness worsened with time: robbing him of his vitality, strength and eventually his independence. By the time I graduated from medical school, he was already too enfeebled to make it to the convocation ceremony though I knew it would have meant a lot to him to be there.

There were the weary rounds of medical consultations and hospitalisations which became more and more frequent, each time leaving him even more debilitated and afflicting the whole family with a sense of bleak helplessness. The slightest exertion would leave him winded and at times gasping for breath. It was painful, terrible and frightening to see.

### HIDDEN THOUGHT

On the eve of Chinese New Year in 1995, my father was again admitted to hospital. Over the next few hours, his condition declined so precipitously that he had to be intubated and moved to the intensive care unit to be supported by a ventilator. Though sedated, he was still conscious but could not talk because of the breathing tube down his windpipe. His arms were restrained to prevent the intravenous lines from being dislodged. He had a feeding tube inserted through his nostril and a catheter draining urine from his bladder.

We kept a vigil outside the ICU, taking turns on and off to see him. On the afternoon of the third day, I was by his bedside and had his hand in mine. I could not find any words to say to him. He looked at me, moved his head, winced and tried to say something. It was then that I wanted

him to die. That thought must have been lying in my subconscious for some time before it broke into my consciousness and once having lodged itself there, it grew. Over the course of the next few days, I pleaded silently with my dying father to let go and not fight any more.

The Japanese writer Minae Mizumura wrote of her exhaustion in looking after her ailing mother who had dementia. "Day after day, I sat by her bedside, exhausted," she wrote. "Mum, when are you ever going to die?"

"To wish for the death of one's mother is universally taboo. Yet technological advances that extend life have driven us to the point where we do just that," she continued. "To admit that one wishes one's mother would die; to forgive oneself for the wish; and to go on trying as best one can to make her happy to her dying day – is this not a true expression of love? For how can anyone riddled with guilt, thinking the unthinkable, find the courage to continue down a seemingly endless road?"

Many of those who read Mizumura's piece which was published in The New York Times wrote to the paper and admitted having expressed similar thoughts. But there were also differing views. One found the article "selfish and mean", another decried "the lack of love towards one's own mother" and that it was "emblematic of modern culture which is so fascinated by convenience".

## END-OF-LIFE ISSUES

Over the next few days, with his lungs getting stiffer and the ventilator already at a high setting (which could burst holes in his lungs at any time), my father's kidneys failed, and he started bleeding from multiple sites and his blood pressure plummeted. Still the doctors persisted. They propped up his blood pressure with drugs and transfused packs of blood products which did not staunch the bleeding.

The senior physician took me aside and said that they could continue to give more blood products. He was a kindly man who clearly did not want to say what both of us had known for some time. Nor did he say what he doubtlessly had thought would be the right thing to do. I went out and huddled with the rest of my family. Then I went back and told the physician to stop, and thanked him. Later that day, my father died.

I did not think it was for a lack of love that I'd wanted my father to die. It was quite the contrary. It was unbearable for me (and for my mother and siblings) to see him suffer – if anything, that was the selfish part of wanting to stop that pain inside me. I feel many things about my father's death, but not guilt. I like to think that my father knew all those heroic efforts were staving off death only briefly and at a terrible cost of suffering to him.

But at the end of the day, I really do not know. I did not have that conversation about what is now called "end-of-life" issues when he was still mentally capable. I had thought of broaching it during his previous hospitalisations, but balked each time. Imbued with that sense of filial piety, it seemed particularly abhorrent to even contemplate the death of one's parents.

Talking about end-of-life issues in the abstract is different from having to initiate that difficult discussion with someone you care deeply for, with all the attendant fears of causing distress, offence and misunderstanding.

When people ask me how best to have this delicate discussion, I'm afraid I don't have any good advice. However, I do tell them that I have signed my Advance Medical Directive – that legal document specifying that should I become terminally ill and unconscious, I would not want any medical treatment to prolong my already ebbing life. That is at least something I can do for myself and to spare my

family the anguish of making wrenching decisions. It will – I hope – also avoid any protracted and unnecessary medical treatment that could be financially ruinous for them.

“Death hath a thousand doors to let out life: I shall find one,” wrote the English dramatist Philip Massinger. The path that leads to our death might be beyond our control, but we might be able to choose one that can possibly avoid a futile, messy and violent end.

15 AUGUST 2014

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## RAGE, RAGE AGAINST THE (PROLONGED) DYING OF THE LIGHT

“A month ago, I felt that I was in good health, even robust health... But my luck has run out – a few weeks ago I learnt that I have multiple metastases in the liver... now I am face to face with dying,” wrote Oliver Sacks in *The New York Times* in February 2015. He continued: “It is up to me now to choose how to live out the months that remain to me. I have to live in the richest, deepest, most productive way I can.”

Most of us cannot tell with certainty how we would respond should we be ambushed one day by a terminal illness – “like some hidden assassin waiting to strike at you”, in the words of poet W.H. Auden (who was a friend of Oliver Sacks). When that happens, we would be brutally compelled to decide on how to live that final stretch of foreshortened future. Very likely, we would also want to “live in the richest, deepest, most productive” manner.

And we would want to die a “good death”, which can be defined by a tabulation of negatives: not to die an untidy death with things undone and unsaid, not to cause too much anguish to our loved ones, not to experience a humiliating loss of independence and bodily functions, not to suffer much pain, and not to die alone.

## BATTLING TILL THE END

In his 1994 book, *How We Die: Reflections On Life's Final Chapter*, Sherwin B. Nuland, a surgeon and educator at Yale School of Medicine, was unsparingly pessimistic about the prospect of a "good death". In his view it was wishful thinking and self-deceiving to even nurse this hope.

"I have not seen much dignity in the process by which we die," he wrote. "The quest to achieve true dignity fails when our bodies fail." Deciding that his chance of a "good death" was slim, he concluded with the epiphany that "the dignity we seek in dying must be found in the dignity with which we have lived our lives". Exactly 20 years later, surgeon Atul Gawande, in his book *Being Mortal*, lamented the bleakness of a modern death: "These days, swift catastrophic illness is the exception. For most people, death comes only after a long medical struggle with an ultimately unstoppable condition."

Most of us do not want to die even when it is utterly hopeless. Nor do we know when to give up, and we persevere to hope against hope. This is engendered at times by doctors who might not know when to stop. The rescue credo is an intrinsic part of medicine: Doctors are trained to save lives and would usually do almost everything to do so. With the panoply of biomedical technologies and therapeutics, medical treatment often continues to the point beyond futility and where each successive measure to prolong life compounds the last and leads to a state of cumulative suffering.

Gawande related the harrowing travail of a 34-year-old woman with inoperable metastatic lung cancer who endured eight months of various treatments, with debilitating side effects and other medical complications, before dying in a hospital. Noting that such is the will to live that even in a situation devoid of hope, "our every impulse is to fight, to die with chemo in our veins or a tube in our throats or fresh sutures in our flesh... We imagine that we can wait until the doctors tell us that

there is nothing more they can do... But rarely is there nothing more that doctors can do... They can give toxic drugs of unknown efficacy, operate to try to remove part of the tumour, put in a feeding tube if a person can't eat: there's always something."

It is likely that things are very much the same here, as suggested by the view of an unnamed doctor who, in a 2014 survey conducted by the Lien Foundation, expressed that the local "healthcare system has been designed to go all out", and even when "doctors realise that they can't do any more medically for their patients... they are not empowered to pull the brakes... Other times there is denial on the part of the patient and/or relatives... leading to increasing costs and more suffering".

In hope of avoiding a nasty and protracted death, I have in place an Advance Medical Directive (AMD), which is that legal document I signed in anticipation that should I be "terminally ill and unconscious", the treating doctors will know that I do not want any "extraordinary life-sustaining treatment" to prolong my life.

The document lies dormant in a drawer in my study, waiting to be kindled one day to thwart any unnecessary extension of my dying. I signed it when I was 10 years younger and in a state of good health. I'd signed it out of my experience as a doctor who witnessed patients dying and of my father's death in intensive care, and based on my personal values and principles about life and death. A part of that document also assured me that I may revoke my AMD at any time in the presence of at least one witness.

The truth is that I really do not know if I would be that same person I imagined, stoically eschewing any heroic life-prolonging interventions when the chips are down, or if I would instead choose to battle on for the chance of a bit more time with whatever means at hand and at whatever costs. Indeed, ample research has shown that when critically ill, people



waver from their advance medical directives. At the point of signing the medical directives, people often underestimate their ability to cope with adversity. But when they do end up in that desperately ill state, they adapt and become more willing to undergo invasive treatment, with limited or even questionable benefits.

And there are other mediating influences that might come into play. The dying person might still find the will and purpose to live by narrowing his life to some focus. This might be some simple pleasure that can still be savoured or an anticipated occasion such as wanting to see a daughter get married or a son graduate from university.

In times of need, we also have an array of coping mechanisms that kick in. These unconscious processes, such as rationalisation, compartmentalisation and denial, are mental barricades that keep those dark fears at bay, buffer us from further emotional distress, and possibly make the remaining time more tolerable.

## HEROIC MEASURES

The interpretation of what is “terminal” and what constitutes “extraordinary interventions”, as laid out in the AMD, is in the hands of the doctors whose actions thus amount to the final act of compliance with a patient’s wishes.

As a doctor, I can understand how difficult this can be, particularly if faced with one of those front-line “in-the-moment” clinical decisions that need to be made fast and where there is no room for dithering. Consider the scenario that Rebecca Sudore and Terri Fried, clinical researchers in the process of end-of-life decision-making, posed: A patient with incurable lung cancer with an expected survival time of at least two years and has an AMD specifying “no heroic measures” and “no artificial interventions to sustain life”. He then develops transient heart failure, which could be

treated. But the treatment would require him to be intubated and hooked up to a ventilator. Does this constitute a “heroic measure” and does it contradict the patient’s stated wish of “no artificial interventions”?

I suspect that in that knife-edge situation, most doctors would go ahead to intubate and ventilate. The ethos of the medical profession would demand that no patient with a salvageable condition should be allowed to die. When torn between what Gawande called “the mistake of prolonging suffering” and “the mistake of shortening valued life”, most doctors would choose to err on the side of extending life.

In the two decades since the publication of *How We Die*, we have made even more advances in keeping people alive, and Sherwin Nuland’s words then are perhaps just as – if not more – relevant in this present time: “We live today in the era not of the art of dying, but of the art of saving life, and the dilemmas in that art are multitudinous.”

We can start to resolve these dilemmas only if we are prepared to talk openly about the art of dying, but I wonder if we are ready and mature enough to do so as a society. In a study among residents in Toa Payoh (published in 2010 in the *Annals of the Academy of Medicine, Singapore*), about a third of the respondents thought the AMD “irrelevant” either because they believed that they would not land in a situation requiring an AMD, or they just did not want to think about death, on the superstition that ill luck would befall them if they do so.

It is uncertain if attitudes have changed in these ensuing years and if we are more willing and able to face up to the obvious fact that we are mortal and that to minimise a bad death, we must continue to have that discussion on end-of-life issues – such as AMD, palliative care and even assisted suicide and voluntary euthanasia – uncomfortable and unpalatable though they may be.

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## THE ART OF DYING WELL

"I'm not afraid of death," Woody Allen once said. "I just don't want to be there when it happens." Alas, death does come looking for us. Despite being a practising doctor for many years and having lived through more than half my expected lifespan, I am still surprised at how uneasy I am when confronted with dying and death.

There is a rather fanciful theory that thanatophobia, the fear of death, is particularly prevalent among doctors and that it operates as an unconscious motive for them to take up medicine in the first place: Being engaged in battle with this ultimately unbeatable foe is a means of assuaging this deep-seated fear. (One is reminded of that adage that medicine is to immortality what law is to justice: The path of each is a little crooked and always ends up way off the mark.)

In the years of seeing patients die and having had to experience the dying and death of friends and relatives, there remains within me – perhaps growing even more acute with the receding years – that abiding death anxiety. In Philip Larkin's chilling poem *Aubade*, a man woke at 4 in the morning and agonised fearfully about "unresting death". At the crux of his terror is that annihilation of consciousness and awareness: "That this is what we fear – no sight, no sound,/No touch or taste or smell, nothing to think with,/Nothing to love or link with,/The anaesthetic from which none come round."

Secular philosophers through the ages have, however, exhorted that

none should fear this absolute dissolution since being dead is akin to a state of dreamless sleep or being unborn – a perpetual nothingness. The focus, hence, ought to be on living and that includes dying since dying, too, is an act of living. “True philosophers,” Plato wrote, “are always occupied in the practice of dying.”

Paul Kalanithi was a 36-year-old doctor who was on the cusp of finishing his training in neurosurgery when he was diagnosed with cancer. He wrote of that moment of confirmation (he had been suspecting it for some time, with his excruciating backache, weight loss and fatigue) that he had Stage 4 lung cancer.

As he methodically scrutinised the CT films that revealed the cancer mottling his lungs and eating into his liver and spine, he registered his initial feeling. “I wasn’t taken aback. In fact, there was a certain relief,” he noted with preternatural calm. “The next steps were clear: Prepare to die. Cry. Tell my wife that she should remarry, and refinance the mortgage. Write overdue letters to dear friends. Yes, there were lots of things I had meant to do in life, but sometimes this happens...”

He spent the remaining 22 months of his life learning how to die – or in the words of journalist and polemicist Christopher Hitchens (on the few months of his own dying), “living dyingly”.

Kalanithi did not divorce his wife; they chose to have a child, he wrote his autobiography entitled *When Breath Becomes Air* – it was the first and only book that he had written. He wrote it for his only child and daughter and for other people “to understand death and face their mortality” and to get them into his shoes and “walk a bit, and say, ‘So that’s what it looks like from here... sooner or later I’ll be back here in my shoes’... Not the sensationalism of dying, and not exhortations to gather rosebuds, but: Here’s what lies up ahead on the road”.

After trying whatever treatments he could find tolerable and

acceptable, and having made a decision together with his family and his attending doctors not to carry on any further, he died with his family at his bedside. If there can ever be one, Paul Kalanithi’s death could possibly be called “a good death” or at least a good enough death.

## A GOOD DEATH

What a good death is is very much in the eye of the beholder, but it is a safe bet that when asked, most people would say that it is a sudden and painless death – and would probably add that this is what they would want for themselves.

I was told of a seemingly apocryphal (it turned out to be true) story of an apparently hale and healthy middle-aged man who was taken out for lunch on his birthday by his colleagues. Back in the office and replete after an extravagant meal, he was in the middle of telling a joke when he keeled over and died. Many who turned up at the wake murmured to the still-shocked and grieving widow that it was good that he did not suffer and that it was a “good death”.

But is it? Such a sudden and unexpected death would usually leave behind a detritus of unfinished and unresolved matters, and a clutch of traumatised survivors who had been denied of being able to express or hear what they have meant to that person, robbed of any opportunity to express gratitude or regrets, and deprived of any hope of reconciliation.

If it is any consolation, most of us would not go this way; we would have to endure that variable period of dying. The intervention of modern medicine can drag this process for months or even years with a progressive accretion of debilities and miseries. It might seem, then, that most of us would have the time to plan for our imminent death: to grieve, to come to terms with things, to provide for others, to try to live out the remaining time with some purpose and meaning, to voice our

preference for life support or not, and plan for our funeral – but we often do not do many of these.

### ARS MORIENDI

In mediaeval Christian Europe, it was widely subscribed that the preparation for one's earthly death and the celestial judgment that would follow were matters of immense importance. Such preparation was even celebrated in the arts and literature as *Ars moriendi*, the art of dying. The *Ars moriendi* provided practical guidance on reaffirming one's faith in God, remembering the right values and taking the right attitude in composing oneself to meet death fearlessly and stoically.

Today, however, we are a "death avoidance" society. Perhaps we are less religious now; maybe our blind faith in medical advances has given us that illusion that we can postpone death each time it comes threateningly close, and our various superstitions and cultural aversion towards death have certainly not made discussion of dying and death any easier.

Since 2006, the Lien Foundation has been at the vanguard of efforts to get some conversation going on end-of-life issues with commissioned studies, campaigns, and media coverage. Despite these valiant efforts, it does seem to be a lone voice in the wilderness as its own research has shown that most people (doctors included) continue to be reluctant to talk about death, even to a terminally ill patient. It is also very likely that the public still possess little information – let alone knowledge – of end-of-life options, including hospice and palliative care, and the legal rights to refuse or withdraw life-prolonging treatments.

We talk about active ageing, but ageing, whether active, well or otherwise, would eventuate in death – yet there is no talk of "dying well". Granted that it is difficult to attend to the thoughts and concerns

of the dying when it is often difficult to be certain of when one actually starts dying; not to discuss it is to ignore – using that stock phrase – that 800-pound gorilla in the room. Unless we are content to put up with its heavy, oppressive and ominous presence, we ought to do something. So, together with active ageing, we should also start talking about our own updated secular or otherwise version of the *Ars moriendi*.

26 JULY 2016

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## A GOOD LIFE TO THE END, OR A QUICK DEATH

The Australian state of Victoria has in 2017 joined the ranks of the Netherlands, Canada, Belgium, Colombia and Luxembourg which have legalised euthanasia. Several states in the United States, including California, Washington, Vermont and Oregon, have passed laws allowing assisted suicide. The Australian law, when enacted, will enable a resident who has lived in Victoria for at least a year, and who has a terminal, incurable illness with a life expectancy of less than six months, to obtain a lethal drug to commit suicide.

In physician-assisted suicide, a physician supplies a lethal drug or suggests a means by which a patient will use it to complete the act that brings about death. In euthanasia, the physician performs the act of directly injecting the medication to cause death. These terms do not apply to a patient's refusal of life-support measures, or to the request for these life-prolonging measures to be withdrawn.

We would think that it would be terminally ill patients with grievous and irredeemable pain who are most likely to want physician-assisted suicide or euthanasia, but the laws permitting this were mainly motivated by the concerns of the "worried-well" – by healthy people who fear the unknown future and the possibility of dying painfully, and who want that control and assurance that they can have the legalised means to end their lives if things become unbearable.

But empirical studies of physician-assisted suicide and euthanasia in the Netherlands and the United States indicate that pain played a relatively minor role in motivating requests for assisted suicide. These studies showed that in only 11 to 32 per cent of all cases was pain the reason for requests for euthanasia.

Depression, general psychological distress, and fear of a loss of control or dignity, of being a burden, and of being dependent on others, were the common reasons. This prompted Ezekiel Emanuel, Professor and Chair of the Department of Medical Ethics and Health Policy at the University of Pennsylvania, to ask if the wishes of these patients should then be granted. He followed with this riposte: "Our usual approach to people who try to end their lives for reasons of depression and psychological distress is psychiatric intervention – not giving them a syringe and life-ending drugs."

### SLIPPERY SLOPE

One of the biggest – and perennial – concerns of legalising physician-assisted suicide and euthanasia is that it will lead to the "slippery slope".

The slippery slope argument contends that even a relatively conservative law like the Victorian model would evolve over time, becoming more permissive and with the right to receive assisted suicide extending to many others: from physician-assisted suicide for the terminally ill and fully consenting adults to euthanasia for patients who cannot give consent – the unconscious, severely disabled children, and the mentally ill.

And it seems to be happening in a couple of countries.

In the Netherlands, which was the first country to legalise euthanasia in 2001, there is the Groningen protocol. Written in 2004 at the University Hospital of Groningen, it was authorised by the Dutch Association for

Paediatric Care the following year as a national guideline to help doctors decide when to actively end the life of a newborn.

These include infants with severe underlying disease who will die despite optimal care; infants with severe brain abnormalities or extensive organ damage who are dependent on intensive care; and infants with a hopeless prognosis who do not need intensive care but experience what parents and medical experts deem to be unbearable suffering.

An example of this last group would be a child with the most serious form of spina bifida (a congenital birth defect of the vertebrae and spinal cord) who is expected to have an extremely poor quality of life despite many operations.

Belgium, which legalised euthanasia in 2002, further amended its law in 2014 to allow for the euthanasia of terminally ill children. The law also allows euthanasia for patients suffering “unbearably” from any “untreatable” medical condition, terminal or non-terminal, including mental disorders. The law has been used for patients with autism spectrum disorder, eating disorders, bipolar disorder, and major depression – which, as a psychiatrist, I find profoundly disturbing.

Psychic suffering is often temporary and, with proper treatment, patience and time, would lessen, and the labelling of even severe mental illnesses as “untreatable” is truly questionable as the course of these illnesses may fluctuate; the prognosis is uncertain; and in no way would mental illnesses be considered “terminal”. Further, the presence of a mental disorder could affect the mental capacity to make an informed decision regarding ending one’s life.

The slippery slope argument also raises a practical concern: If assisted suicide were legalised, there must be regulations to ensure that a patient’s decision for suicide is informed, competent, and made without any external coercion. There must be a tight process of robust

vetting, assessment and consultation. The doctor has to provide detailed information, including the diagnosis and prognosis, and possible treatment options, and assess the patient’s mental capacity to make that fateful decision.

But the danger is that such regulations and safeguards cannot be adequately enforced in practice, and that particularly vulnerable patients – for example, the aged and those with severe disabilities – might be pressured into accepting assistance in dying when they do not really want it.

There may be that additional indirect pressure when the onus of responsibility is being shifted to these patients who may then be seen to have the power to end their suffering; and refusing would be seen as the patient’s own doing – something which might even engender resentment in overwrought caregivers who are physically, emotionally, and financially exhausted.

## PALLIATIVE CARE

I have lived long enough and worked long enough as a doctor to witness heart-wrenching cases of individuals who suffered a slow and difficult death, and in such instances, assisted suicide and even euthanasia seemed to be the most humane option.

But I’m troubled by the potential effect that the legalisation of physician-assisted suicide and euthanasia would have on doctors should such measures become routine and we become too comfortable in prescribing and giving injections to end life. It seems anathema to what doctors do, and violates a core tenet of the Hippocratic Oath that we had sworn the day we became doctors, which is “first, do no harm”.

And, it could also undermine the nature and quality of the doctor-patient interaction which is a relationship that is built on trust; most

dying patients, even when suffering, would also want to live as long as possible and expect their doctors to respect this and trust that they would help them and not push them to end their lives.

We certainly would not want to raise the spectre of Jack Kevorkian, the Michigan pathologist who in the 1990s went on a zealous crusade to assist some 130 people to end their lives with his makeshift "suicide machine" that administered a lethal injection to them or allowed them to inhale carbon monoxide before he was convicted of second-degree murder and imprisoned.

But neither is the alternative – indeed, the only option – easy.

"Providing the terminally ill with compassionate care and dignity is very hard work," writes Ezekiel Emanuel. "It frequently requires monitoring and adjusting pain medications, the onerous and thankless task of cleaning people who cannot control their bladders and bowels, and feeding and dressing people when their every movement is painful or difficult.

"It may require agonising talks with dying family members about their fears, their reflections on life and what comes after, their family loves and family antagonisms. Ending a patient's life by injection, with the added solace that it will be quick and painless, is much easier than this constant physical and emotional care."

And he warns that resorting to this quick way of exiting, which also obviates all this hard work, would be tempting and makes it difficult not to use it, particularly in an overburdened healthcare system.

In his book *Being Mortal*, surgeon and writer Atul Gawande also cautions that this "capacity" of assisted suicide could "divert us from improving the lives of the ill". He thinks that the growing number of assisted suicides in the Netherlands, where the system has existed unopposed for decades, is not a measure of success but a measure of failure.

He posits that it could be because the Dutch have been slow in developing a system of palliative care and this tardiness stems from their entrenched system of assisted suicide and euthanasia that might have "reinforced beliefs that reducing suffering and improving lives through other means is not feasible when one becomes debilitated or seriously ill".

The goal of assisted suicide/euthanasia and palliative care is purportedly to relieve suffering, but their means are different: the former does it by stopping life while the latter tries to reduce suffering by treating physical, psychosocial and spiritual distress.

A study published in the *New England Journal of Medicine* in 2010, which evaluated the potential benefits of early palliative care among a group of patients with terminal lung cancer, described the "specific attention" given to assessing "physical and psychosocial symptoms, establishing goals of care, assisting with decision-making regarding treatment, and coordinating care on the basis of the individual needs of the patient" as part of palliative care.

The researchers found that those who received palliative care not only chose less aggressive therapies but also lived longer and had better quality of life compared to those who received the usual care.

The truth is that even if the most terrible pain in a terminally ill patient can be eased, there could be other distressing symptoms like nausea that is the side effect of powerful pain-relieving medication, extreme fatigue, breathlessness, the humiliating loss of bodily functions, and the terror of impending death. But these may be indicators that not everything possible has yet been done and perhaps, we have to hunker down and do more of the sort of hard work described by Emanuel.

If we could ensure that terminally ill patients have access to good palliative care and compassionate mental health attention, then we would probably think less and want less of assisted suicide and euthanasia.

The medical profession is dedicated to preserving life when there is hope of doing so, and even if there is no more hope and death is imminent, we should and could alleviate suffering. "Our ultimate goal, after all, is not a good death," Gawande said, "but a good life to the very end."

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## WHEN A CHILD DIES

I have before me a copy of the second edition of *Farewell, My Child* — which is a collection of 39 short memoirs of parents whose children had died. This was published by the Child Bereavement Support (Singapore), a voluntary group that renders support to parents who have lost a child.

The preface of the book has this portentous warning: "Such stories can tear you apart. They can be exhausting, consuming and fill you with fear." And that fear is all the more greater because it is something that most parents wouldn't and couldn't think or imagine of — after all, it should be the natural order of life that children should outlive their parents but the universal truth is that children don't necessary live.

Together, these 39 stories are an inundating flow of laments; each a narrative of the turmoil of emotions following a child's death. One after another, they are as relentless and stabbing as the onslaught of grief that the writers have experienced.

### SIMILAR, YET UNIQUE

In most, there was that initial frantic involvement of medical specialists and other health-care professionals who seemed to withdraw just as abruptly following the death — leaving the grieving parents to cope as best as they could. While some of these professionals were "wonderful in their compassionate understanding", as recalled by one grateful parent, others were found to be maladroit and even callous. (Another



aim of the Child Bereavement Support is to work with the medical and care professions to provide sensitive and compassionate care to bereaved families.)

In the immediate aftermath of these deaths, there was “shock, grief, rage, horror, disbelief”, wrote one mother who lost her 23-month-old son, which was “heart-breaking, soul-wrenching, spirit-breaking”. Then there was that headlong plunge into a world for which there can be no preparation.

“Grief turns out to be a place none of us know until we reach it... We might expect if the death is sudden to feel shock. We do not expect the shock to be oblitative, dislocating to both body and mind,” wrote the American essayist, Joan Didion, following the sudden death of her husband of 40 years.

Twenty months later, her daughter died at the age of 39 after an extended illness which she subsequently described in her book *Blue Nights*. This second loss had, for her, “cut loose any fixed idea I had ever had about death, about illness, about probability and luck, about good fortune and bad, about marriage and children and memory, about grief, about the ways in which people do and do not deal with the fact that life ends, about the shallowness of sanity, about life itself”.

The death of an adult child brings particular tribulations and what resources could help younger parents heal after a child's death are less available for older parents who are unlikely to have more children or simply can't any more; and if widowed, they cannot draw comfort from a close marriage which is a demonstrated source of support.

In this period of grieving, relationships with others are often tested; some may hold true, others may be found wanting, while others need recalibrating. The bereaved survivors would have to put up with the awkwardness of friends and associates who may have difficulty

finding the right words or else offer clumsy hackneyed expressions of condolences. Often, the bereaved might feel that they would be judged by others and held responsible in some ways or that it is something that no one else would like to talk about, so they suffer in silence.

## GRIEF: THE PRICE WE PAY FOR LOVE

And they suffer the pain of grief because it is the inevitable price that they pay for their love and commitment to that person. The manifestation of this sort of grief varies from person to person, and the intensity fluctuates from moment to moment. The specific features and their trajectory over time are unique for each person. They may be overwhelming immediately after the loss; they may occur in searing pangs or come on as heart-aching bouts of grief – often evoked by some internal or external reminders of the deceased. But research has shown that most of come out of it reasonably well and will manage to regain their equilibrium and not to go pieces.

But there is a small proportion – studies indicate about 10 per cent of bereaved people overall – who can't seem to recover, and continue experiencing intense acute grief; and parents who had lost their children are particularly vulnerable. In this situation, the bereaved person continues to have strong pining for the one who died.

Sometimes the yearning is so profound that thoughts turn to finding ways to be closer to the deceased – even to the extent of contemplating suicide. There are frequent thoughts or images of that person coupled with either an almost obsessive preoccupation with, or a phobic avoidance of, anything associated with the loss. There might be this endless loop of rumination about the circumstances or consequences of the death.

Mental healthcare professionals call this “complicated grief” and view it as a form of disorder. Without professional intervention and

treatment, complicated grief can be chronic and persistently disabling. It can lead to severe depression, alcohol abuse, post-traumatic stress disorder and suicide.

Intriguingly, brain imaging studies reported in 2008 by researchers at the University of California at Los Angeles showed that in those with complicated grief, a region of the brain called the nucleus accumbens is activated when shown images of the deceased. On the other hand, those who adapted well to their loss showed no activation of the nucleus accumbens, even though they may continue to feel sad.

As the nucleus accumbens is the brain-reward processing centre, the researchers postulated that the “pleasure” – if it can be called that – that the individual gets from keeping the memories of the loved one alive and the craving reinforce the habits that prevent the resolution of the grief.

In *Blue Nights*, Didion wrote of wanting to cling on to some reminders of her daughter – hoping that these would evoke some cherished memories. But she abandoned them when she realised that it wasn't healthy. “In fact, I no longer value this kind of memento. I no longer want reminders of what was, what got broken, what got lost, what got wasted. There was a period, a long period, dating from my childhood until quite recently, when I thought I did. A period during which I believed that I could keep people fully present, keep them with me, by preserving their mementos, their ‘things,’ their totems.”

Suffering and loss are inevitable in life, and for our preservation, our brain seems wired to deal with these terrible events without incapacitating us so grievously or permanently.

For some, that painful loss could have some epiphanic or redemptive value. Emerging from that dark nether place, some transformative insight might be gleaned, wisdom might be acquired, unrecognised strengths discovered, and relationships redefined and deepened. A sense

of purpose in life can still be found and detained. And some would resolve to do something positive in the wake of suffering – like those parents who came together to start the Child Bereavement Support to give succour and foster resilience in the face of great grief.

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## WHEN PATIENTS KILL THEMSELVES

**I**t was from the newspaper that I found out about the death of my patient. In the obituary column was the photograph of the patient whom I last saw at the clinic not too long ago. There was no mention of the cause of death, but I knew it was suicide – you somehow have that unerring intimation – which was later confirmed by the coroner's inquest.

I had then recently obtained my postgraduate degree in psychiatry and this patient was among the first few I had attended to without direct supervision by a senior psychiatrist. The patient was a mechanic in his early 40s who had lost his wife two months earlier to cancer. The cancer was diagnosed late and the end was swift but emotionally traumatic; she left two young children and a husband who missed her terribly and was crushed by his loss and overwhelmed by the responsibility of bringing up the children on his own.

More than 20 years on, I can remember just as clearly that moment when I saw that grainy black-and-white photograph in the papers and that ferment of emotions: shock, disbelief, guilt, a sense of failure, shame, loss of self-confidence and even – seemingly unreasonable and narcissistic – anger and an injured sense of betrayal at the patient for giving up on treatment and afflicting this on me. I remember, too, that tortured self-interrogation: “Did I miss something vital? Could I have done more or done or say something that I shouldn't?”

And there was that fear of being sued. Suicide is the one of the leading causes of lawsuits brought against mental-health professionals in the US. The grieving family of the patient is often left with many unanswered questions and could easily feel angry at the doctor to whom they had entrusted the care of patient to, and when things go so terribly and unexpectedly wrong, they could just as easily believe that there could be some negligence in failing to provide that basic standard of care.

## OCCUPATIONAL HAZARD

The loss of a patient from suicide is a harrowing experience and a particular occupational hazard for psychiatrists; some who have been scorched by it find it difficult to continue – hobbled by a crippling sense of inadequacy and fear of it happening again. What I experienced was common to those who had suffered such losses. Almost all psychiatrists would have experienced this if they'd practised long enough. The American Association of Suicidology which has founded a support group called the Clinician Survivor Task Force for mental-health providers, has this quote on its website: “There are two kinds of therapists: Those who have experienced the suicide of a patient and those who will.” Studies indicate that 50 to 70 per cent of psychiatrists would lose at least a patient to suicide at some point, and 40 to 50 per cent experienced the loss while in training.

It remains an irony that while most psychiatric training programmes scrupulously teach and emphasise suicide assessment and prevention, the trainees are often not taught how to manage the suicide survivors, and process their own feelings when it happens.

## SUICIDE AND MENTAL ILLNESS

The majority of people who kill themselves suffer from some sort of mental illness. Roughly 20 per cent of patients with untreated

depression kill themselves; 10 per cent of people with schizophrenia will do likewise, and the suicide rate of people with bipolar disorder is around 15 per cent. As psychiatrists, we tend to see such acts as the tragic consequence of mental illness and arising from a reasoning that has been impaired and distorted by that illness. Suicide, viewed in this perspective, is something that can and should be prevented as there are effective treatments for these mental illnesses.

And so we sometimes are prepared to take extreme measures such as forcibly admitting a person to hospital and enforcing treatment. This is never an easy decision to make as it often requires coercion, depriving an already distressed and resisting person of his freedom and keeping him under close watch in a restrictive environment – all of which can be very frightening and traumatic. And when the suicide risk seems high, the conventional wisdom is to err on the side of doing what we can to preserve that life and to fight for some time for the patient and for us to treat him or her.

But there would always be some patients whom we cannot help despite our best efforts. Statistically speaking, we expect a certain proportion of individuals with certain mental disorders to kill themselves. But when it happens to one of your patients, that death is no longer a statistic but is experienced as something profoundly personal and almost always unexpected.

I have had, since the first suicide, a few other patients who killed themselves in the past two decades or so. Each event evoked more or less that same train of emotions but in a more attenuated form. I dwell less on them – “one more suicide, to stack upon the others”, as John Berryman (whose father committed suicide and who himself would jump to his death from a bridge) writes in his poem on the suicide of fellow poet Sylvia Plath.

I follow the drill of reviewing the medical records with colleagues for any slip-ups, omissions, oversights, and clues for some kind of understanding of what led to that fatal act. I would call the bereaved family and offer to

see them as a sort of “closure” (though that seems rather doubtful to me).

Meeting with the family is something I cannot get used to, and I have always done it with a sense of nervous unease and apprehension. But in all these meetings, I have never experienced any recrimination and anger from the bereaved family members who either seem resigned or, more often in their pained bafflement, would ask questions to which I have no answers. Still, I like to think that these meetings have helped them; they have certainly helped me as I needed to know that they weren't angry with me, something that I seized upon as partial absolution and salve for my conscience.

I have become more adept at reining in my emotions. And perhaps, I have attained that certain distance that is essential to our profession. But I also worry if I might have distanced myself too far. We will never be able to predict suicide with absolute certainty. We can, however, try to ascertain proneness to suicide based on our past collective clinical experience and research. They inform us that a suicide is usually preceded by previous attempts or expression of suicidal intent; among the elderly who are socially isolated and with physical illness; among those who are divorced or widowed; among those who suffer loss in relationship or job; and among those with serious mental illness.

While it is not reasonable to expect that psychiatrists would be able to prevent suicides of all patients under their care, it is reasonable, however, that we should strive to do so for every single one of these patients.

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