

“Why Hospice?”

By Dr Seet Ai Mee

“Why hospice? Isn’t it an unusual choice for a non-medical person?” This question was posed to me by Dr Jeremy Lim, SMA’s guest editor for this month’s theme issue on palliative care. My answer to him, “Why not?”

Tracing the history of palliative care in Singapore, the strongest advocate for hospice care in Singapore was not a doctor but an accountant, Dr Ee Peng Liang, the “father of charity”. Dr Ee, among his many charity projects, fathered the hospice cause in those early years when death and dying were still clothed in superstition and when the government was not supportive of starting homes, fearing they would be likened to the infamous Sago Lane death houses.

Furthermore, when we look through the lists of people working in hospice care – both full time staff and active volunteer helpers – we see an amazing cross-section of people: doctors, nurses, lawyers, administrators, accountants, architects, bankers, leaders in businesses, publishers, journalists, media artists, home-makers, students, retirees and many more. Hospice work is about caring for

the dying and it concerns and involves everyone. That a biochemist, not a medical doctor is one of the lead persons in the movement further substantiates this.

How did I get involved? It was 1992 and I was looking for new challenges after politics. I had been involved with community work in the decade before and I felt that I should return to it. I looked into several possibilities in areas of need and spoke to two good doctor friends. Both suggested I should work in “an area of neglect”. One suggested “elderly or nursing homes”, the other “hospice”. I asked Dr K, “Why hospice?”

His wise answer was, “Two reasons: first because you are a Christian there is no fear or superstition related to death and dying, and secondly, and perhaps more importantly, your own nature. You are task-oriented; you like to see the beginning and the ending and are impatient in character. For the elderly, the process of decline is slow, too slow for you. With hospice care, the time span for a patient is short; you can see the beginning and the end and finally there is a very great need there.”

I took his advice and 18 years later, am still on the hospice treadmill.

Hospice has been a marvelous journey and learning experience for me – it has been like parenting all over again. I was not at the birth of hospice care in Singapore but was there when it was very much a baby, and saw the baby grow into a child, a teenager and into young adulthood. In the mid-1980s, the first few hospice beds were in St Joseph’s Home and the first home care team worked from a university lecturer’s apartment in Gillman Heights. When the first purpose-built hospice was mooted in 1992, there were student protests about its location in Dover road, so plans for Dover Park Hospice (DPH) were transferred to Jalan Tan Tock Seng. To this day, Singaporeans are still confused about the location of DPH, expecting it to be in the Dover road vicinity. Today in the young adulthood phase of hospice care, now termed palliative care, there are four establishments for in-patient care, four providing home care services and four major hospitals with palliative medical services.

In the early years, palliative medicine was not an area of choice for any doctor or nurse. Years of intense engagement with policy makers culminated in 2007, which will always be remembered as a watershed year for palliative medicine as it was finally recognised as a sub-speciality for the medical profession in Singapore and today, young Singapore doctors and nurses are choosing to work and specialise in this oft-considered “depressing” and “dead-end” area.



SINGAPORE HOSPICE COUNCIL

One day in 1994, several of us from various hospices were invited to tea with the then-President of the Republic of Singapore, Mr Wee Kim Wee. In his wisdom, he advised that we should work together and under Dr Ee Peng Liang's leadership, we put together the Singapore Hospice Council (SHC), the umbrella body for all hospice organisations in Singapore. Sadly Dr Ee died before SHC's formal registration and left me his big shoes to fill.

Under SHC's scope came public and professional education, international representation and "Voices for Hospice", a once in three years (since 2008 it has become a biennial event) singing event when hospice bodies all over the world sing for hospice work. Many countries use this for public education and fund-raising. SHC was one of the founding members of the Asia-Pacific Hospice Network, and has supported the network well by hosting its headquarters for the first decade of its existence. The network headquarters is now located in Seoul, Korea. As the world moves into celebration of World Hospice and Palliative Care Day, observed on the second Saturday of October each year, SHC with its member bodies conducts events and projects for public education.

SHC ran the first courses in palliative medicine for doctors and nurses. Nurses doing their oncology specialty have since the opening of DPH been attached there for two weeks as part of their training. As Singapore is recognised in the region as a centre of excellence for palliative medicine, SHC has been working with other agencies such as the Singapore International Foundation to support palliative care doctors and nurses going out to neighbouring countries like Vietnam and Indonesia to conduct training for staff there.

Seet Ai Mee was born and grew up in Malacca. She came to Singapore to work as a clinical biochemist, moving on to a wide spectrum of employment and community and welfare work. She co-founded Dover Park Hospice in 1992 and in the last 18 years has been a voice and advocate for Hospice and Palliative Care.

The funding scene has shifted, from zero government subvention to means tested subvention, which means that most hospice services in Singapore get government funding for 30 to 40% of the service costs; the rest is from fund-raising from the community and donations from foundations, supportive corporate bodies, the public and also grateful families of patients. However, only medical services are government subvented, psycho-social services are not. This is an area we continue to work on to persuade policy makers as we believe strongly that palliative care must be about the holistic care of the "whole patient" and his/her family.

Has hospice care arrived? Is there more to do in the future? What do I see the young adult hospice organisations growing up to become? In our ageing community, it is not difficult to forecast that the need for palliative care will increase. There will be need for more hospice beds, be they located in stand-alone hospices, major hospitals, or in nursing homes. There

last ten years has increased but currently still hovers at about 50 to 60%. As children are born, go to schools and higher educational institutions, there is a need to open their eyes to the needs of the elderly and dying. They need to learn that birth and death are but phases in one's life and at whatever age, they can play an important part in caring and being there for the sick, especially their own family members.

When I came onto the hospice scene I only saw the immediate need – hospice beds, nurses, doctors, training and education of professionals, and some public education and support. It was a very myopic though focused view. Today, with the experience of age and time I see that for hospice care as with all needs in life, the spectrum of need and training involves not just doctors and nurses but all people. End-of-life care is not very different from care required at birth and a child's early months – yes it does involve medical and nursing care but more importantly, it involves mothering, fathering and brothering. Hospice

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will be diversity in location and in level of care. Such is life and such is the "natural history" for illness as it progresses from low to high to acute and finally, intensive care. There is a need to grow our nurses to higher levels of professionalism and responsibilities as they work with acutely-ill patients in their homes and community. Volunteers and family as care givers will be needed to walk with patients physically and emotionally and we will need to train them well to empower them in their care giving and counseling roles. I also see a need to develop teaching modules in care giving, training Singaporean adults to be paid caregivers, a job especially suitable for homemakers who have left the work-force for a period and want to return to some paid part-time work.

Public acceptance level for hospice and palliative medicine in the 1990s was poor and almost non-existent. Education of the public was needed then and is a continuing area of need. Much effort has been made in the last two decades through media, print, TV and even the Internet. Awareness level of hospice in the

encompasses medical, psycho-social care, the family and the larger community.

Beyond the acceptance of hospice care is the need to give the dying a dignified send-off – a developed nation should do no less than give that to loved ones who have strived and built our country and homes and families. We have moved from third world to first world. Having achieved beyond bread and butter needs, we can and should do better for our elderly and those who are leaving us.

I have intentionally not mentioned all the names of pioneers and those who have contributed to making hospice care what it is today. These are myriad and this article is not about a "National Honour List". The hospice scene has been enriched by their giving of skills, time, talents and money. To all from the most generous philanthropists, to the doctor and nurse pioneers, and to all the volunteers, I am deeply grateful – it is all of you who have grown hospice care to what is today and you deserve the nation's thanks and gratitude.

Why hospice? Why not? **SMA**