Being Human

Stories from Family Medicine

Second Edition

Commemorating the 50th Anniversary of the College

Cheong Pak Yean & Ong Chooi Peng
Editors

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Edited by Cheong Pak Yean & Ong Chooi Peng

Text by Family Physicians

Drawings by Medical Students of Yong Loo Lin School of Medicine,
National University of Singapore

A Publication of the

COLLEGE OF FAMILY PHYSICIANS
SINGAPORE

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Book design by Yiling Liw
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Cover photograph by Ong Chooi Peng
The cover photograph shows a riot of zinnias in a late summer garden. The blooms are glorious in their colours and messy in their bed. Life is glorious and messy too. We hope this book reflects a bit of that.

50th Anniversary of College of Family Physicians Singapore Stamp Set (CSK21AST)
The stamps are part of a commemorative local issue released in July 2021 and are reprinted with permission. They showcase family physicians' many roles across multiple settings. We are proud to be part of this jumble.

Printed and bound in Singapore by Oxford Graphic Printers Pte Ltd

First Printing, 2019
Second Printing, 2021

Hardcover ISBN 978-981-18-2285-8
Digital ISBN 978-981-18-2286-5

Being Human: Stories from Family Medicine
Cheong Pak Yean, Ong Chooi Peng
1st Edition
Hardcover ISBN9789811414602
Softcover ISBN9789811414640
LCSH (Library of Congress Subject Header)
1. Narrative Medicine 2. Graphic Medicine 3. Family Medicine

Acknowledgements

We gratefully acknowledge the forty-three doctors who have willingly shared their reflections and experiences. The great majority of them are family physicians, and the couple who are not have been closely connected to the Family Medicine fraternity.

The drawings in this book were produced by successive cohorts of medical students participating in the *Pictures from the Frontline* workshops from 2012 to 2017. We are grateful that they have been generous with their work. Fong Seng was head of the Family Medicine division during those years and his support sustained the workshops. And Joon Sin, in his final year of medical school, kindly took time to help us communicate with the different classes of students.

We also acknowledge Lee Gan, old friend and mentor, for his ideas that helped to conceptualise this book. Our old compact to sharpen each other remains a compact for learning and support to this day.

Tze Lee and the College secretariat have undertaken much of the work in getting this book to publication. We have been comrades in yet another foray.

For the second edition, we are delighted to present a poem by Kirpal, as a non-medical commentary on the work that we do. We are also especially glad to close the book with two cartoons by one of our pioneers. Readers will quickly recognize them as wry medical commentaries on the work that we do!

Lastly, we gladly acknowledge our families and our patients, who have journeyed with us from the time we were young practitioners, and have seen us grow into our grey hairs. They have helped shape who we are.

Table of Contents

	page
Acknowledgements	iii
Message	vi
Foreword	vii
Poem	viii
Preface	ix

Chapter One: The Doctor and the Patient

1.1	Coming Alongside	2
1.2	The Key of Empathy	4
1.3	Compassion and Hope	6
1.4	Communication	8
1.5	Internet-ism	10
1.6	Masquerades	12
1.7	*Chao Geng*, or Any Other Name	14
1.8	The Unseen Patient	16
1.9	Beyond Comprehensive Care	18

Chapter Two: Challenges to Care

2.1	Common Conditions: Or Not?	22
2.2	Reality	24
2.3	Non-Adherence	26
2.4	Non-Compliance	28
2.5	The *Tai-Chi* of Care	30
2.6	One Appointment Per Organ	32
2.7	Smoking Cessation	34
2.8	Addictions	36
2.9	The Curse of the Blessed	38
2.10	Traumatic Injuries	40
2.11	Good Employers	42
2.12	Communicating Across Assumptions	44
2.13	Pregnancies	46
2.14	Leaving the Children Behind	48
2.15	The Plague of Epidemics	50
2.16	Outbreak!	52

Chapter Three: Family and Sexuality

3.1	When Life Changes	56
3.2	Still Waters Run Deep	58
3.3	The Invisible Problem	60
3.4	Fostering	62
3.5	Child Abuse?	64
3.6	Sexual Boundaries	66
3.7	Sex Matters	68
3.8	Size Matters!	70
3.9	The Seed	72
3.10	Discovered!	74
3.11	Replay	76
3.12	Fears and Misses	78
3.13	Detecting Pregnancy	80
3.14	The Psychosocial Conundrum	82
3.15	My Sister, My Daughter	84
3.16	Who Are You?	86
3.17	Gender Identity	88
3.18	Still Family	90

Chapter Four: Being Human

4.1	The Girl and the Doll	94
4.2	Social Isolation	96
4.3	Lonely and Unloved	98
4.4	Disability and Social Inclusion	100
4.5	In Their Shoes	102
4.6	Transitional Care	104
4.7	Unspeakable Anguish	106
4.8	They Don't Want Me Home Anymore	108
4.9	Nursing Home Tales	110
4.10	Sorrow	112
4.11	Gladness	114
4.12	Seasons in the Sun	116
4.13	Pulling the Plug	118
4.14	Assisting Suicide	120
4.15	A Description of Dying	122

Chapter Five: In Practice

5.1	The Business of Medicine	126
5.2	Who's the Boss?	128
5.3	Regulatory Matters	130
5.4	Electronic Medical Records	132
5.5	Proper and Improper Influence	134
5.6	Medical Adverse Events	136
5.7	Occupational Risks	138
5.8	Work-Life Balance	140
5.9	Balancing Act	142
5.10	More Choices	144
5.11	Doing Good and (Not) Harm	146
5.12	Physician, Heal Thyself	148
5.13	Life is a Journey	150
5.14	Art and Science	152
	Epilogue	154
	About the Drawings	155
	About the Editors and Contributors	156
	Further Reading	160
	Index	163
	Last Words	164

Message

Looking back, looking ahead

I am truly honored and privileged to be part of this fraternity of family physicians. This book puts together many bite-sized stories, anecdotes, and reflections to remember how far our community has come. We get to see different aspects of health care delivery, and the ideas and aspirations of the contributors provide an insightful glimpse into their lived experiences.

2021 is also the year we celebrate the 50th anniversary of the College of Family Physicians Singapore.

This is a good time to remind ourselves of the contributions of the founding stalwarts of the College. Doctors Sreenivasan, Wong Heck Sing, Victor Fernandez, Koh Eng Kheng, and Lee Suan Yew laid the foundation that succeeding generations of family physicians built upon to create the suite of training programs we have today within the College.

We have so much more to do in training future generations of family physicians and in honing their skillsets and expertise to deal with our rapidly ageing population and their changing care needs. My wish is that College will build upon the foundation of the past fifty years and, in the next fifty years, forge ahead into broader partnerships with academia, practising physicians, and patients.

Congratulations!

Dr Tan See Leng
Minister for Manpower and 2nd Minister for Trade and Industry
September 2021

Table of Contents

Foreword

As we celebrate the College's 50th anniversary, it is our great honor to present the 2nd edition of *Being Human: Stories from Family Medicine*.

This is a book that has been long in the making. Based on a series of drawings by third-year medical students, it is a collection of seventy-two sets of essays by forty-three experienced family physicians and specialists.

The book explores various aspects of the human condition in the practice of medicine in five sections. *The Doctor and the Patient* looks at the doctor-patient relationship and all it entails. *Challenges to Care* highlights some of the difficulties we face in providing care – fragmentation, fear of treatment, the not-my-business syndrome etc. *Family and Sexuality* deals with some topics we do not often openly discuss. We are all very comfortable talking about family, but not so with sexual issues!

Being Human is all about our human condition, and the vignettes plumb the depths of the therapeutic relationship. There is a bittersweet lesson on every page. The last section, *In Practice*, deals with the realities of working as a doctor. From the business of running a practice, to self-care and the pressures of balancing work and family, the various stories touch on much of medicine that doesn't make the headlines but affects us all profoundly.

Enjoy the book for what it is: a window into the medical experience through the eyes of young exuberant medical students, an exposé by senior practitioners who have seen more, and a celebration of the beauty and humanity of medicine.

Adj Assoc Prof Tan Tze Lee
President, College of Family Physicians Singapore

Being Human

means trying to fathom.
love features
among the myriad images
turning and twisting
minds roaming, wandering.

we settle and pause.

writing turns to poetry
and prose awaits attention
as the lesser of two twins.

being human means
giving oneself a chance
to reboot and re-boost.
the blood in the veins
forms remembrances
deep feelings and thoughts
as our being, frail and fraught,
tested and feasted and rested
finds its locus, settles
amidst comforting memories.

time passes and may heal
wounds implanted and minded.
sorrow upon sorrow, and
joy unto joy rejoicing
the triumph of bonding.

the above – a riddle for our medics.
so continues the elixir quest
as op. after op. after op.
challenges and taunts
new frontiers.
and new cures.

— Kirpal Singh
april 2021

writer, poet, critic, thinker

Table of Contents

Preface

This book is the work of a fraternity.

Family Medicine is a privilege. It is the discipline that allows us the most intimate glimpse into the lives of our patients over a lifetime.

For medical students, the glimpse begins in earnest in the third year of medical school, with the Family Medicine posting. These students have contributed their observations of family practice over a succession of cohorts. Following on that, practising family physicians have reflected on the drawings that they found meaningful, and added insight that the years have allowed them. The editors did not impose a structure or suggest a slant to these reflections.

This book, then, combines the fresh strokes of beginning practitioners with the lines of seasoned artists, and together we have a lovely picture. It has been our privilege to be family physicians and to be part of this work.

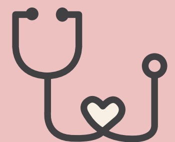
This is a special year for our fraternity. We are proud and grateful to celebrate the fiftieth year of the College in 2021, and we are unabashedly glad to present this edition in honor of the milestone.

Cheong Pak Yean & Ong Chooi Peng
Editors

Table of Contents

Chapter One

The Doctor and the Patient



COMING ALONGSIDE

Our most important role as a physician is being a comforter to the sick.

— *William E. Cayley Jr*

Commentary

The patient's journey is a lonely one. When we are sick, beset by challenges, distressed, or overwhelmed, we see nothing beyond our misery, and others may not see what we see.

As doctors, we wield our pen and scalpel so confidently, but we are often impotent when the patient is weighed down by the burden of his illness. Perhaps at such times we can learn to put aside our prowess and simply be the patient's encourager along the way to recovery and healing, or the fellow traveller who has seen enough to offer a tip or two.

Not so much *I'm sorry you have to go through this*, but *I'm here if you need me*. Not merely to offer the skill of training but simply to attend and be present. Perchance this compassion may be the source of strength for the patient to confidently and squarely face his own challenges.

Many doctors can treat. If we are privileged, we may be part of the healing.

— Dr. Irwin C. A. Chung

Table of Contents

The Patient's Tale

I had a patient with poorly controlled diabetes who had recently lost his father to colon cancer, and wanted cancer screening for himself. His tests were positive and an urgent colonoscope revealed a large tumour in his sigmoid colon. The full work-up took almost three weeks before a decision on surgery could be made, and during this time I saw him a couple of times for investigation and management of his other chronic diseases.

Essential interventions aside, those sessions were opportunities for him to share his concerns, fears, and uncertainty about his health and the future. It did not matter that his diabetes control was not yet at target. I am certain more healing took place during those few exceedingly long consultations than all of my other encounters with him combined.

— Dr. Irwin C. A. Chung

THE KEY OF EMPATHY

Doctors at the frontline of contact and care are usually the ones to first face a spectrum of undefined and uncategorised symptoms. How we parse these symptoms may make a difference between whether we are effective in meeting the patient's needs, or not.

Commentary

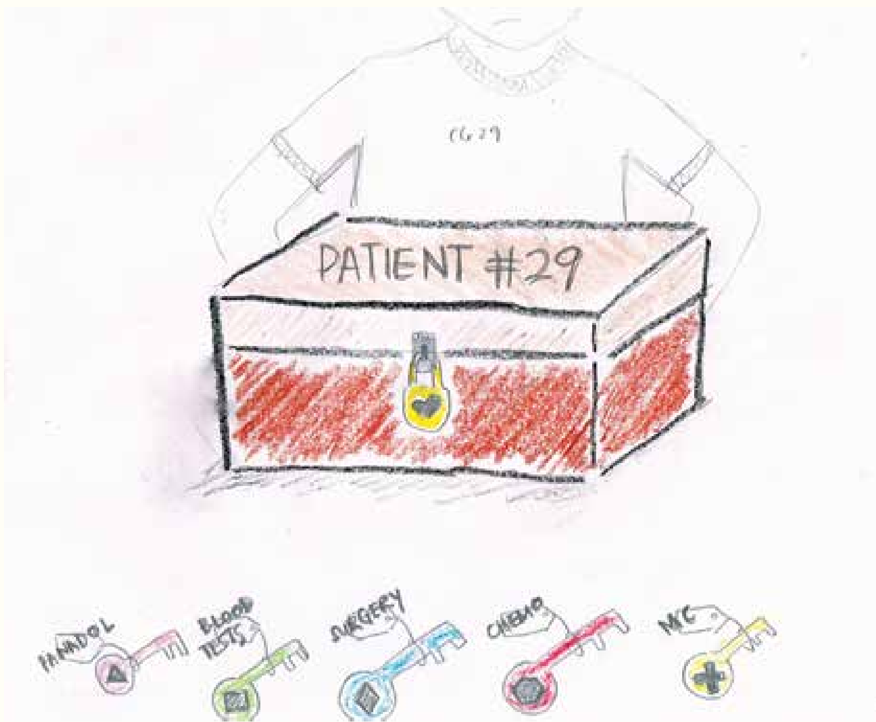
The drawing depicts a nameless patient who is identified only by a number. He carries a box with a lock. The box holds the patient's true problem, packed up in layers of his ideas, concerns, and expectations. The doctor needs to choose the correct key, or keys, with which to unlock the box and to understand his patient.

Which key holds the secret to this deep understanding? The choice ranges from easy cures to the potentially toxic. One can organise a battery of tests and suggest a range of therapeutic options. And yet perhaps one additional key is missing. What is also needed is a listening ear, empathetic responses, and genuine compassion.

A good clinical consultation can be more than a process towards a diagnosis and treatment plan. The consultation itself can be a therapeutic process by which the patient develops a better understanding of his illness. In the process, the box is unlocked for both the patient and his doctor.

— Dr. Darren Seah

Table of Contents



Listening

Madam J was an elderly lady with well-controlled hypertension. By the time I met her, she had had consultations with multiple specialists, including a neurologist for headaches, a psychiatrist for sleep problems, a gastroenterologist for dyspepsia, and an otolaryngologist for episodes of vertigo.

In my initial consultation with her, she once again presented with various symptoms without any objective signs, and absent a clear diagnosis for any of her complaints.

As I explored her social background and living arrangement, it was evident that she was lonely. I listened to her for twenty minutes as she went from one story to another, mostly unrelated to any medical issue.

At the end of the consultation, Madam J did not request any medications and I did not offer to prescribe any. Instead, we agreed on a review visit in two months.

— Dr. Darren Seah

COMPASSION AND HOPE

To cure sometimes, to relieve often, and to comfort always.

It is said that Ambroise Paré gave us that insight five centuries ago. We have advanced a lot since. Our patients live longer lives and are generally stronger and better off. However, the givens of human life remain – suffering, pain, and death. What M. Paré said all those years ago rings true today.

Commentary

When there is no hope for cure, care continues. The patient must not feel that she is "discharged". *This is the end. It's all over*. The family doctor can collaborate with the patient (collude with even, against fate!) to *make the best out of this*. He can be the nexus of care, the co-ordinator, and the advocate. His mind-set affects the patient's response to her afflictions.

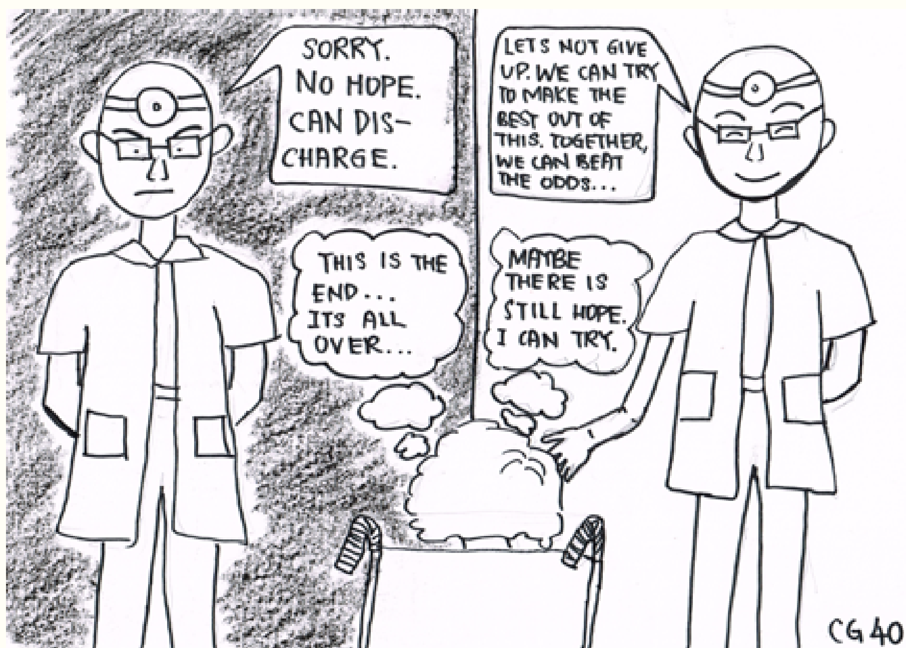
Compassion for a fellow human's afflictions is a key to the holistic care provided by the doctor, quite apart from the medicines prescribed, laboratory tests ordered, office surgery done, or medical leave issued. His care bag includes a listening ear, comforting touch, a heart to empathise with, and commitment to a steadfast relationship with his patient.

Does the family doctor need a GP clinic? Perhaps the question is not so much, *where is his clinic?* but rather, *what makes a family physician special?*

When we ask the second question, the answer can be unexpected. We begin to see that family medicine is defined not by the presence of an ambulatory clinic, but by the ethos of providing comprehensive and continuing care to the individual patient.

The attached vignette describes how care continues in the face of despair. The team involved was a family medicine team working in an acute hospital, providing care and advocacy in hospital and on discharge.

— Dr. Ng Lee Beng



Not the End Yet

Mr. See* was a sorry figure lying rigidly in his hospital bed when I first met him. He had been admitted three times in three months and had now developed a deep sacral sore in the three weeks preceding his latest admission. He had Parkinson's disease and according to his son, he had not spoken aloud in ten years.

It turned out that Mr. See had had a difficult few years. He had spent some years in a nursing home but his only son had recently engaged a helper to look after him at home. Unfortunately much of the care had been untutored and haphazard, resulting in Mr. See's repeated admissions and now his sacral ulcer.

As Mr. See got better, we had a long conference with his son and presented options for care, including post-discharge home support, caregiver training to the family, and financial aid. It was a relief to him that such support was available.

As for Mr. See, he became more cheerful as he got stronger. One day, as his son visited, he proclaimed loudly, *this is my son!*

*Not his real name

— Dr. Ng Lee Beng

COMMUNICATION

The single biggest problem in communication is the illusion that it has taken place.

— George Bernard Shaw

Commentary

Time was when the doctor said and the patient did. The framework was unapologetically authoritarian. Doctors, teachers, and parents all knew best. Those were the days of a legion swift consultations, and the good doctor depended on touch and telepathy to reach his patient.

Communication frameworks have changed. Mindsets have altered radically. Patients expect – and sometimes we doctors tell ourselves patients expect even more – detailed discussion before management. We tell patients the options available. We tell them the expected consequences of their potential choices. Also, we tell them all material foreseeable problems!

What we talk about has changed. *If you don't watch your sugar I will have to start insulin*, we said. *Here's what we can do*, we say instead, now. *What are your goals of care? What values matter to you? Do you want antibiotics? Do you want tubes? How are you doing in school? What does your partner think?*

The languages have changed. It's no longer just the four main languages and the usual Chinese dialects. Patients come from all manner of other places. Some come with all manner of expectation of politically appropriate language too. And of course, doctors' language capabilities have changed. The old doctor who spoke any number of Chinese dialects and Tamil to boot has given way to the modern graduate, schooled in proper English.

What has not changed, I think, is us doctors thinking we communicate effectively.

— Dr. Ong Chooi Peng

Blah, Blah, Blah

A doctor had just attended a lecture on dietary strategies in patients with elevated cholesterol. He enthusiastically put his new knowledge to use with the next patient he saw, who had raised LDL-cholesterol, and delivered a discourse on how to make better food choices at the hawker centres. When he finished, the patient looked at him and said *But doctor, I do not eat hawker fare.*

— A/Prof Cheong Pak Yean

Aaah, Aaah, Aaah

She announced her presence in the clinic by a succession of loud, agonised groans. A series of strokes had left Madam W severely dysarthric and dependent. Over time, we learnt that she groaned the most when she was unwell with fever and urinary infections. Doctors like to say that patients are our teachers. I learnt to be humble from Madam W.

— Dr. Ong Chooi Peng

INTERNET-ISM

Patients sometimes come requesting that we manage their ailments based on what they have learnt (or mis-learnt) from the internet. Alas, this may sometimes hamper good care.

Commentary

The doctor-patient relationship is built upon a traditional information asymmetry. The doctor has relevant information that the patient lacks. Out of this asymmetry, professional governance and ethics dictate that the doctor makes decisions in his patient's best interests.

The internet has changed this. The world wide web, freely accessible, can dramatically increase the amount of health information the patient is exposed to. At the same time, if the information that is trawled is not relevant or contextualised, the therapeutic relationship can be disrupted.

Knowledge Is Power. Does more information equal more power? Unbridled information from the internet has given some patients a false sense that the information asymmetry has now shifted in their favour. A *faux* literacy is born, untempered by professional discernment or emotional detachment.

The drawings tell us that to some patients, their doctor takes third place to Google and *my friends*. To remain therapeutic in such consultations, doctors need skills to handle this new "information symmetry".

— A/Prof Cheong Pak Yean

Table of Contents

A Tale of Two Patients

Once, a patient consulted because he feared he had leukaemia. In truth, his weight loss was because he had not taken his diabetes medication as prescribed. Both his fear and non-adherence resulted from misconceptions gleaned from surfing the internet. After a dialogue during which his ideas and fears were voiced and addressed, he agreed to start taking his medications again.

A second patient had high LDL-cholesterol unresponsive to life-style and dietary changes. He steadfastly declined statin therapy because of fear of potential side-effects, again resulting from online research. When the doctor explored his ideas, he turned combative and declared, *I am the expert!*

— A/Prof Cheong Pak Yean

MASQUERADES

Masquerades often show up in a consultation. The patient's presenting complaint may be a guise of his true agenda. Perhaps he is embarrassed and prefers not to share something too personal such as a struggle. Perhaps he lacks the words to describe his symptoms by, from a language barrier, or learning difficulties, or dementia. Or he may purposefully seek to deceive for secondary gain.

Commentary

Bizarre as it sounds, unmasking the complaint to get to the root of the problem is an essential doctor's skill. However, one does require extra time and effort to probe deeper, and we may not always choose to do this. When we take everything at face value, the consultation proceeds on a superficial and transactional level.

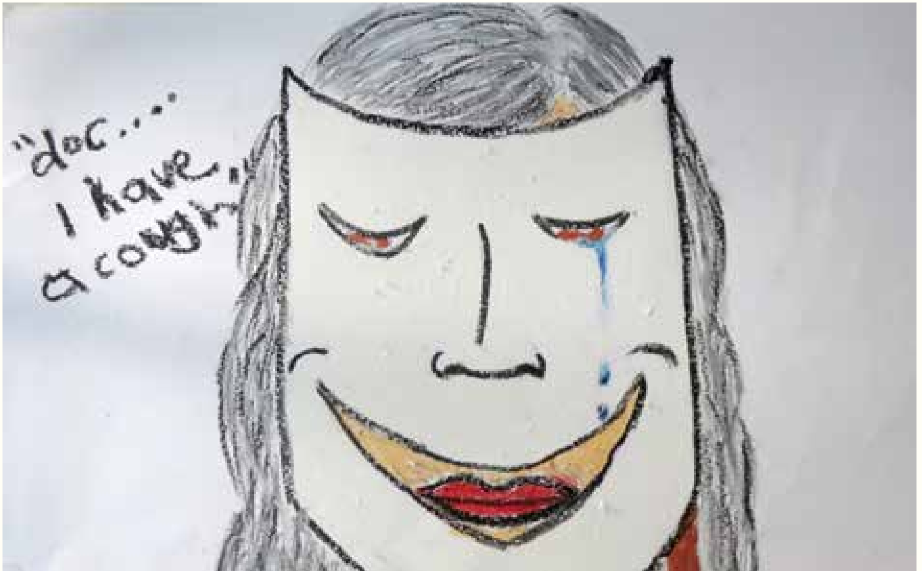
I have encountered several elderly patients presenting with headaches, who turned out to be having sleepless nights worrying over a family member or a life situation. We have the option of treating the headache with a prescription for analgesia, or of probing deeper and managing the issue more holistically.

The young man in the vignette seeking help to lose weight had a more dramatic backstory. He was in a romantic relationship, knew he was infertile from Klinefelter* syndrome, and had insufficient words to express his distress.

— Dr. Linus Chua

*Klinefelter syndrome is a genetic condition where the patient is a male, but has an extra X-chromosome in his cells. As a result of the additional chromosome, the patient is infertile.

Table of Contents



Weight Watchers Anonymous

An obese thirty-year-old man wanted to lose weight before his wedding. He had dieted and used appetite suppressants unsuccessfully, and now came to me for counselling and behavioral modification.

I guided him to envision a thinner image of himself. As we worked on visualising well-formed chest muscles, his face contorted in agony and he broke down in tears. He had seen well formed breasts instead of muscles!

He confessed that he had been diagnosed with Klinefelter syndrome during his school days. Naturally his mother knew about this, but they had never talked about it again after diagnosis and after he had decided to default all follow-up. This dark secret haunted him now that he had proposed marriage to his girlfriend.

The diagnosis of Klinefelter syndrome was his damning reality. Obesity was his masquerade.

— A/Prof Cheong Pak Yean

CHAO GENG, OR ANY OTHER NAME

Patients with Munchausen syndrome feign disease or psychological trauma, to draw attention, sympathy, or reassurance to themselves. If there is external gain for doing it, it is called* malingering. *Neither term is often encountered in the medical records of family practice. Instead, the term used by many doctors in Singapore to describe such patients is* Chao Geng, *which is Singlish for stinking imposter. It is a term that is never written in the records.*

*Munchausen syndrome is a mental health condition where a person acts as if he has an illness when in fact he does not.

Commentary

The medical students observed that a number of physical diagnoses are commonly assigned to the *Chao Geng* patient. Doctors tend to give the benefit of the doubt to such patients and may not be able to fully investigate the veracity of the complaints. Their priority is to ensure that serious biomedical issues have been excluded.

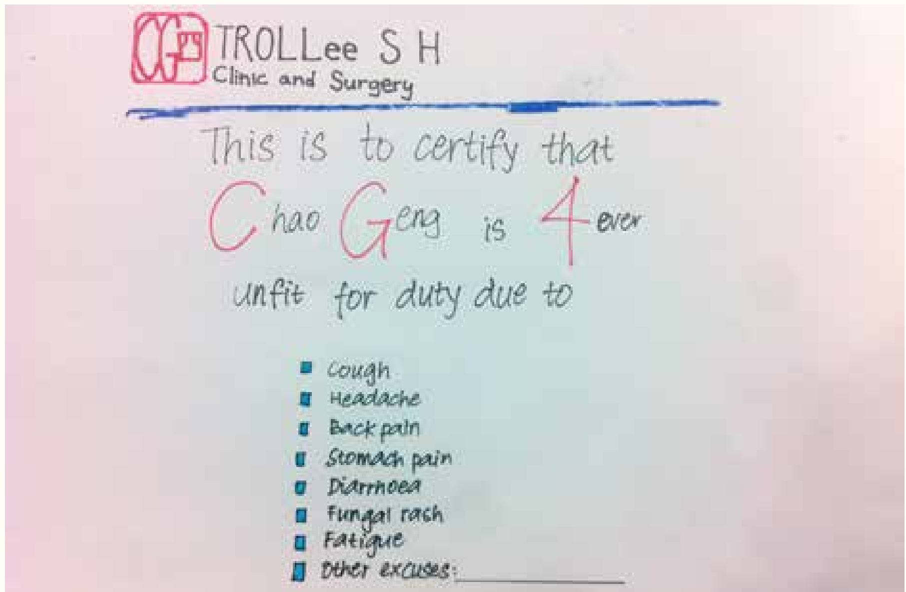
The situation becomes distressing to the doctor when such a patient presents with a history that may portend serious illnesses, which is not readily excluded by careful questioning or examination. The patient described in the vignette presented with an acute onset of unsteady gait and giddiness. The absence of positive neurological signs does not mean the absence of a serious neurological problem.

The situation was clarified by the use of the Columbo technique* of distraction to catch the patient off-guard. With the patient's subterfuge exposed, the doctors distanced themselves in stages. This, rather than direct confrontation, lessened the risk of the patient accusing the doctor of maligning her!

— A/Prof Cheong Pak Yean

*This technique is named after the detective in a television series popular in the USA in the 1970s. Columbo liked to get his suspects comfortable and relaxed, and then he would uncover the truth by asking an unexpected question that caught them by surprise.

Table of Contents



I Came by MRT!

My resident doctor, K, and I saw the patient together. The healthcare assistant provided an ominous introduction: *She is very unsteady. She fainted and fell in the reception area.*

The patient appeared distant, giving short answers with no elaboration. We decided to quickly do a neurological examination. As we helped her from the wheelchair to the couch, she slumped, almost destabilising us. Was this a serious condition? If so, a normal examination would not exclude that. *Should we refer her to the emergency department? Do we get an ambulance? If we refer to a neurologist urgently, how is she travelling there?*

As K engaged the patient's attention in the physical examination, I casually asked the patient how she had come to the clinic. *By MRT,* she reflexively responded. I turned to K to ask where the MRT was. While still examining the patient, K replied easily, *a ten-minute walk from here, first down the stairs after the station, then the escalator, then walking along the shops…*

The woman's composure did not change but when K finished with the examination, she got off the couch unaided and walked by herself to the consultation chair.

— A/Prof Cheong Pak Yean

THE UNSEEN PATIENT

Munchausen syndrome by proxy, also termed factitious disorder imposed on others, *is the deception of illness not in the protagonist but rather in someone under that person's care. Like the classical Munchausen syndrome, this diagnosis is seldom made in a family doctor's clinic. In truth, however, experienced family physicians have encountered many patients with this disorder.*

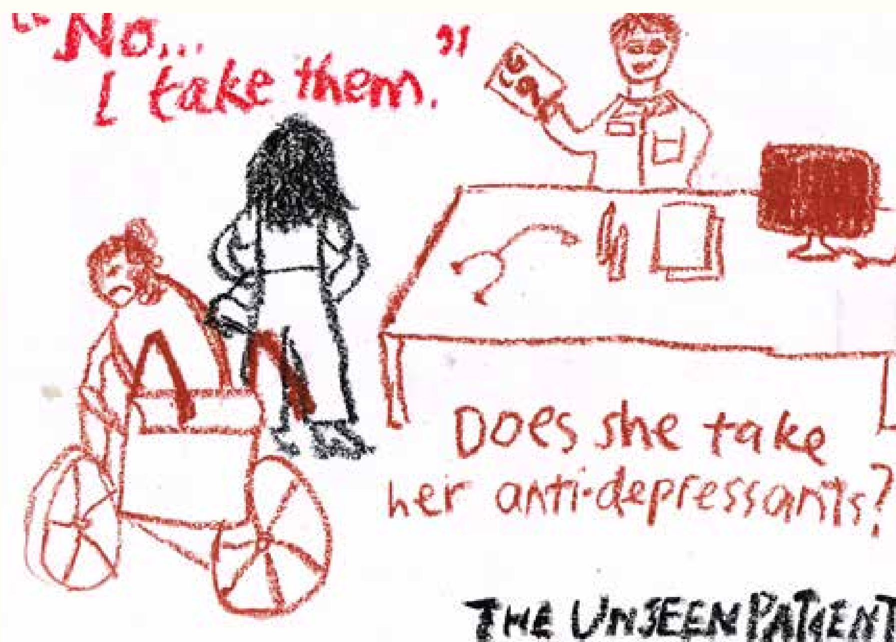
Commentary

The medical students caption their drawing *The Unseen Patient*. The registered patient is the elderly woman in the wheelchair. The doctor asks whether the patient is taking her anti-depressants as prescribed. At this, her carer, the younger woman, confesses in a flash of candour that she takes them instead. The carer has imposed her own symptoms upon the elderly woman to obtain medication for herself.

The accompanying vignette is familiar to family physicians. We often see how illness is projected onto another family member. Superficially, the diagnosis for Lucy's consultation is given as influenza-like illness. This is technically correct, as under the strain of anxiety and lack of sleep, her resistance to viral infections has decreased. Technical correctness, unfortunately, may not be sufficient to help Lucy in this case.

— A/Prof Cheong Pak Yean

Table of Contents



Brain Problems

Lucy* consulted her regular family doctor for headache and fatigue. She was exhausted from caring for James*, her hospitalised twelve-year-old son, and for her new-born baby.

James was Lucy's son from her first marriage. James' father had died of a brain tumour seven years ago, and James was under the care of his paternal grandmother when Lucy remarried. Grandma believed that brain diseases ran in the family genes, as her own husband – James' paternal grandfather – had died of a haemorrhagic stroke many years ago.

With this projected vulnerability to brain diseases, coupled with the pressure of the Primary Six promotional examinations, James started to display many medically unexplained neurological symptoms. On grandma's insistence, James was admitted to the hospital for investigation.

All investigations turned out normal. Who is the patient?

— A/Prof Cheong Pak Yean

*Names have been changed.

BEYOND COMPREHENSIVE CARE

We often talk about the biopsychosocial model of care. Perhaps we should add a spiritual component to the equation as well!

Commentary

At times, doctors deal with paranormal phenomena. Patients may report seeing ghosts in their homes and even hear ghosts talking to them. Relatives may be "demon-possessed", hexed by black magic. If there are manifestations of psychiatric illnesses, referrals to psychiatrists should be promptly made. Sometimes though, these may be spiritual or cultural problems of living, and not psychiatric in nature. One example is a wife insisting that her straying husband is possessed by black magic cast by the other woman.

The medical students who drew the picture were so impressed by *My all-powerful GP* attending to one such patient that they bestowed upon him a super-hero costume, a glowing halo, and a magical mace. Skills to handle such situations are not specifically taught in medical school. It requires understanding of the culture, religion, superstition, and beliefs of the patient, a strong therapeutic alliance, and an ability to think and act out of the box and from experience.

Respect for the patient's world-view is of utmost importance, while also focusing on the therapeutic objective. The distraught mother in the first vignette is given hope so that she remains grounded to continue caring for the child. Many parents blame themselves for bringing a malformed child into the world and doctors can help alleviate this guilt. In the second vignette, the medical priority is that the patient takes the allopurinol.

Beyond the biomedical and psychological, patients at times do consult their family physicians on problems of living that may be spiritual and even paranormal in nature. The compleat family physician attends.

— Dr. Julian Lim

Table of Contents

To Comfort Always

A mother was overwhelmed when told that her child, born with inoperable complex heart deformities, would not survive infancy. Yet the family doctor did not refuse to provide the infant with routine vaccinations and developmental assessment. The day came when the infant was bought in dead to the clinic. The doctor performed a brief resuscitation, lest the mother blame herself for not bringing the child in earlier. An umbrella was then used to shelter the deceased child to the ambulance as the superstitious believe that the soul would otherwise wander to the open sky. This doctor attended to more than the child alone.

— Dr. Julian Lim

Witch Doctor

A man inflicted with recurrent gouty arthritis was unshakeable in his belief that it was caused by *datuk*, the malevolent earth spirits he had stepped on, and refused medication. He only agreed to take allopurinol when the doctor convinced him that the pill when taken daily was the magic talisman that would prevent those spirits from intruding. The man did not have any more gouty attack!

— A/Prof Cheong Pak Yean

Chapter Two

Challenges to Care

COMMON CONDITIONS: OR NOT?

Treating common conditions is not always as straightforward as it appears. As the doctor of first contact, the family doctor has to be mindful of masquerades that might lead him astray, red flags that he can ill afford to ignore, and psychosocial issues that impact on the management.

Commentary

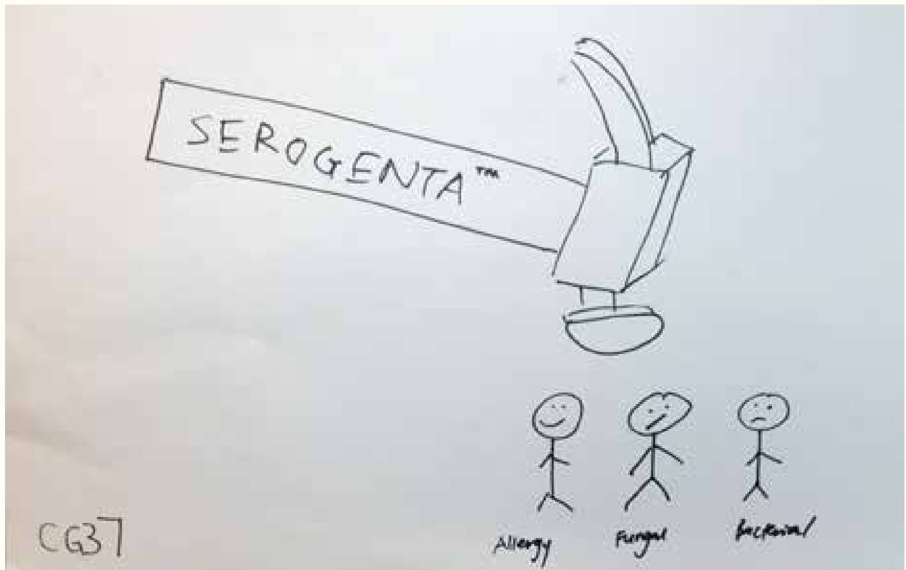
I would like to address two common conditions in this commentary – upper respiratory tract infection, or URTI, and skin infection. In the 2014 survey of primary care in Singapore, URTI was the top diagnosis in all primary care encounters, and skin conditions were the sixth most common. A sound clinical approach to these common conditions will serve us well.

URTI is a syndromic diagnosis. The classic symptoms and signs present together to suggest the diagnosis, but there is no test that confirms it. It is important to remember that when symptoms and signs are not localised to a site, the diagnosis may not be URTI, even though it is the commonest condition presenting to primary care. We might be dealing with a viral illness, or generalised conditions such as infectious mononucleosis, or influenza-like illness. The vignette describes a URTI that turned out to be dengue fever.

The drawing relates to the treatment of skin diseases. The exact diagnosis of a skin rash can be uncertain, as the patient may present very early in the course of disease. It can be tempting to prescribe an all-in-one cream with steroid, antimicrobial, and antifungal components. Unfortunately, such a blunderbuss approach contributes to therapeutic uncertainty when adverse reactions occur.

Common things happen commonly. The challenge is recognizing the uncommon among them.

— A/Prof Lim Fong Seng



The URTI That Wasn't

A twenty-four-year-old woman had already seen two previous doctors and had twice been diagnosed with URTI.

She now presented on the sixth day of her fever, with headache and sore throat. Clinical examination was unremarkable except for a mild fever. Her blood was tested and showed neutropaenia and thrombocytopaenia.

A provisional diagnosis of dengue fever was subsequently confirmed by polymerase chain reaction studies. The patient was monitored and she recovered uneventfully.

— A/Prof Lim Fong Seng

ALTERNATIVE REALITY

In secondary school, I once sat through a lecture by an alternative medicine practitioner. He described how a combination of dinosaur egg and traditional herbs had cured a prominent politician of his lymphoma. I remember thinking then that the politician must have also received care from western-trained doctors too!

Commentary

When I think of alternative medicine and serious diseases like cancer, I think the issues boil down to just this – the interplay of fear and hope.

In the process of offering treatment, the modern doctor is bound to disclose the benefits and harms of his proposed options. The patient, already under the weight of his diagnosis, is easily overwhelmed by this, and fear can rapidly set in and drive him to seek alternative treatment options. We doctors are always concerned that alternative medicine may be offering the patient false hope at a time of great duress. If true, this is tragic, regardless of the good faith in which the hope is being offered.

The drawing depicts the alarm that we western-trained doctors feel when we see the patient taking alternative remedies and serenely ignoring the fire as it burns the house down around her, taking her with it.

A study by Johnson *et al* showed that when alternative medicine was used as the sole anti-cancer treatment, it was associated with a greater risk of death. News reports tell the same story. One such report in January 2019 tells of a young child who perished after herbal remedies were used to treat his cancer.

Do we know too little to judge? Are we looking at oranges and judging them like apples? Fortunately, when the stakes are not so high, as with less serious conditions, we judge less, and less hastily.

— Dr. Vincent Chan

Table of Contents

No, Thank You

I have an elderly patient who was recently diagnosed with third stage sigmoid colon cancer. He had just had his operation and was scheduled to begin radiation therapy next.

However, he decided not to proceed with radiation. His older brother had had radiation therapy for a brain tumour and had died after two cycles of treatment. He was sure the therapy had hastened his brother's death and was determined to avoid this himself. Instead, he started on traditional Chinese herbal treatment.

He told me he believed the herbs were actively killing the cancer cells. To this I blurted out, *how do you know?* His reply was silence.

— Dr. Vincent Chan

NON-ADHERENCE

When you say you agree to a thing in principle you mean that you have not the slightest intention of carrying it out in practice.

— Otto von Bismarck, German chancellor

Commentary

Gaining insight to why our patients do not do what we tell them to do is the first step toward helping them. Have they been properly educated about the disease? Do they understand what is at stake? Is there a learning barrier?

At the same time, more information may not translate into improved compliance. Studies have shown no change in compliance irrespective of knowledge levels, including understanding of the consequences of non-compliance.

Neither has compliance been definitively linked to severity of condition, despite extensive research. As with much of life, patients' reasons for not doing something are multi-faceted. The reality of living with an illness, the burden of the treatment regimen, and the emotional distress and stigmatisation, are among many factors that strongly affect what our patients do, irrespective of disease severity.

The drawing shows a woman with poorly controlled diabetes, living life on her own terms, discarding her medications and enjoying all the goodies she loves.

There are many reasons for her defiance. She may be in denial despite her non-healing ulcer. She may be apathetic from previous bad experiences. Lack of trust in her doctor, a complicated drug regimen, unpleasant side-effects, or even cost of her medicine may play a role. Or she may have decided that life on her terms, now, is simply what she wants.

— Dr. Lim Chee Kong

Your Time, My Time

How much time do I have with you, doctor? The fifty-year-old woman, seeing me for the first time, shouted across the table in my consultation room. I caught myself and replied that she could have as much time as she needed for her condition.

She had long-standing poorly controlled diabetes and was also seeing a psychiatrist for co-dependent personality disorder. She came from a single-parent family with two younger siblings, and she was not on speaking terms with her family. She wasn't taking her diabetic medications as prescribed because she didn't see the need to do so.

From her body language, I could see that the patient was taken aback by my response. Fortunately, the rest of the consultation, and our subsequent relationship, went more smoothly than expected. My offer of a listening ear somehow provided her with the impetus towards medication adherence. Her glycosylated haemoglobin went from 11.5 to 7.9 percent over the next year and a half.

Sometimes we are blessed with unexpected partnerships.

— Dr. Lim Chee Kong

Table of Contents

NON-COMPLIANCE

Judge tenderly, if you must.

— Traci Lea LaRussa

Commentary

Social factors influence the health outcomes of our patients, especially those with chronic diseases. These include the conditions in which our patients are born, grow, live, work, and age. They contribute towards decisions on priorities, health choices, and lifestyle preferences.

Our current care plans for chronic diseases such as diabetes are mostly focused on managing biologic and behavioural factors, for example symptom recognition, or diet and exercise advice. Increasingly, however, we recognise that low income, unemployment, poor living conditions, and insecurity impact on health outcomes as much as poor diet and little exercise.

The drawing depicts the genogram of a young family trapped in its social and financial nightmare. Mum is heavily pregnant and has diabetes, requiring insulin injections. Dad is in prison. The youngest child is an infant, still swaddled. The older children are drawn with downcast faces. *The baby is not gonna have a father* is a sad commentary on the family's near-term expectations.

As physicians, we are concerned about the mum's pregnancy. Diabetes in pregnancy carries its own burdens of dietary restriction, intrusive blood glucose monitoring, increased medical costs, and higher risk of poorer outcomes. On the other hand, the woman clearly has more than her diabetes to worry about.

We need to look beyond "non-compliant" behaviour in our patients to the underlying social and economic circumstances that may first need to be addressed.

— A/Prof Chong Phui-Nah

Table of Contents

Do You Know My Pain?

No, I don't want to start insulin injections. Just let me die! The elderly Chinese woman was struggling with deteriorating diabetic control. I suggested speaking with her son. *I don't want to be a burden to my son!*

Slowly, it emerged that her only son had recently been diagnosed with lung cancer and was in remission after treatment, and he was then unemployed. She did not want her medical expenses to burden him. As we discussed her health and what mattered to her, she realised that she needed to be healthy so that she could care for her son. She learnt to self-administer the insulin injections, and with the social worker's help, she eventually found a job as an office assistant.

— A/Prof Chong Phui-Nah

FRAGMENTATION OF CARE

Many patients have an additional disease when they suffer from their ailments. This extra co-morbidity is fragmentation of care. Care fragmentation increases with increasing number of ailments, as care needs become more complex and require input from multiple providers.

The Tai-Chi *of Care*

Continuity of care is a universally accepted priority. We recognise that fragmented care can be ineffective and harmful. Following our precept to *first do no harm*, no one ever sets out to design a healthcare system that is intentionally fragmented or discontinuous. And yet unfortunately, the way we organise and fund healthcare can result in serious discontinuity.

We organise healthcare delivery according to organs and diseases. We physicians create our careers along similar silos. Professionally and financially, we are rewarded for providing care in parts.

Healthcare workers on the ground are often forced to cope with this part-by-part apportioning by behaving in ways that aggravate the situation. This is illustrated in the Tai-Chi *of Care* pictogram. The poor patient is caught in the centre of the whirlpool of the *tai chi* dance, kept away from the ideal of a medical home.

Can we really blame the system? We are the system.

— A/Prof Lee Kheng Hock

Family
CG41

FRAGMENTATION OF CARE

With the increasing complexity of medical care, medicine is organised into specialty groups based on body parts or treatment modalities. While such groupings are important for medical research and training, there is a danger of dividing patients up based on organ systems for care across the entire spectrum of disease severity. The patient ends up with one appointment for each dysfunctional organ system.

One Appointment Per Organ

The drawing depicts a bewildered wheelchair-bound patient with a host of specialist outpatient appointments following an acute admission. Sometimes such splintered care in disparate clinics may lead to a poor outcome. The patient in the vignette subsequently defaults some of his appointments, has another stroke, and dies.

We need to integrate clinical silos into the healthcare landscape by some common concepts and common action, aided by patient health literacy. Clinical practice guidelines and care pathways cannot substitute for doctors working in tandem and in harmony. This refers to specialist and generalist doctors. The specialist-centric model needs to give way to a more collaborative partnership with the generalist. The generalist needs new rules of engagement to participate in integrated care.

The question that we need to face is not *Who* but *What*. What is a generalist and what is a specialist? We can agree that the generalist is the doctor who is not organ-defined – hence the general physician, the geriatrician, and the family physician. Like specialists, these doctors have undergone structured training and assessment to get to where they are, and they each practise within a definite framework. It is time to recognise that the generalist is not distinct from the specialist. In the integrated new world, the generalist, looking after the whole person, is simply distinct from the one who looks after specific body parts.

— Drs. Cheong Pak Yean, Goh Lee Gan, and Ong Chooi Peng

Table of Contents

Medicine Not Enough

I remember the forty-year-old blue collar worker with a homemaker wife and a young child. He had stopped taking carbimazole for Graves disease* for a few months, because attending a polyclinic for medication meant an ill-afforded half-day off work. One night, he developed right-sided weakness, a complication of atrial fibrillation from uncontrolled thyrotoxicosis.

In a home visit I made with medical students after discharge, we found that he had five appointments all on separate dates – one each for the neurology, cardiology, and endocrinology specialist clinics, and two others for speech therapy and physiotherapy. He had multiple packets of tablets from each clinic, and the students found inconsistencies between the amounts dispensed and the time to the next appointment dates. Luckily for the patient, the students were able to help reconcile some of these discrepancies.

— A/Prof Cheong Pak Yean

*Graves disease is a thyroid gland disorder that can lead to heart and other problems if untreated. This patient's uncontrolled disease unfortunately led to a heart rhythm disorder, atrial fibrillation, which led to his stroke. Carbimazole is a commonly used treatment for Graves disease.

SMOKING CESSATION

I spend much time telling my patients to quit smoking, eat healthier, start exercising, learn to relax, and enjoy life. I suspect most of us do so, and with limited success.

Commentary

After twenty-odd years talking about quitting cigarettes with smokers, I now realise that I don't know what they go through, being a non-smoker myself. I am convinced about the detrimental effects of cigarette smoking, and I think smokers are too. But I have read that because nicotine feeds the pleasure centre of the brain, quitting cigarettes in some can be harder than kicking heroin. I try not to pontificate anymore these days. I just say, *if you can, don't smoke anymore.*

How you do it is not important, I tell them. If you can find a good *Why* to quit, the *How* is not so important.

In the drawing a doctor tells a patient he needs to quit because he has had a stroke, an amputation and a heart attack. The patient's wife and daughter react with joy when the man says that he has. Actually, the fellow continues to clutch on to his cigarette but keeps it out of sight of his family!

— Dr. Tan Su-Ming

Table of Contents

The Girlfriend from Hell

I love it when my patients have an *Aha!* moment.

I met a twenty-year-old man who had a cough he couldn't shake. We got to talking about his smoking habit. He'd smoked his first cigarette when he was twelve and he was smoking twenty a day now.

"You ever thought of quitting?" I asked.

"Sure," he replied, "but it's very very hard."

The cigarette was like his girlfriend from hell, I told him. This girlfriend would take everything from him – his health and his money, and give him nothing good in return. If he tried to break up with her, she wasn't going to let him go so easily.

"Exactly," he said. "Damned hard to break up with this girlfriend of mine."

"What is your girlfriend's name?" I asked.

"Winston*," he smiled, not missing a beat.

— Dr. Tan Su-Ming

*Winston is an American brand of cigarettes.

ADDICTIONS

We have all encountered this in primary care in one form or another. Usually the patient does not look like a "drug addict". It could the business traveller who just needs a few sleeping pills for jet lag. Or the smoker who can't stop despite knowing the harms that cigarettes bring. Or the patient who swears he (or she) only has a few drinks on the weekends. Recognising the addicted patient is a skill I didn't practise until I graduated and started to work independently.

Commentary

In general practice, a sub-acute cough that stretches on is a common enough complaint. We think of various biological causes such as infections, or smoker's cough, or reflux, or any of the conditions we store in our *approach to prolonged cough* algorithm*.

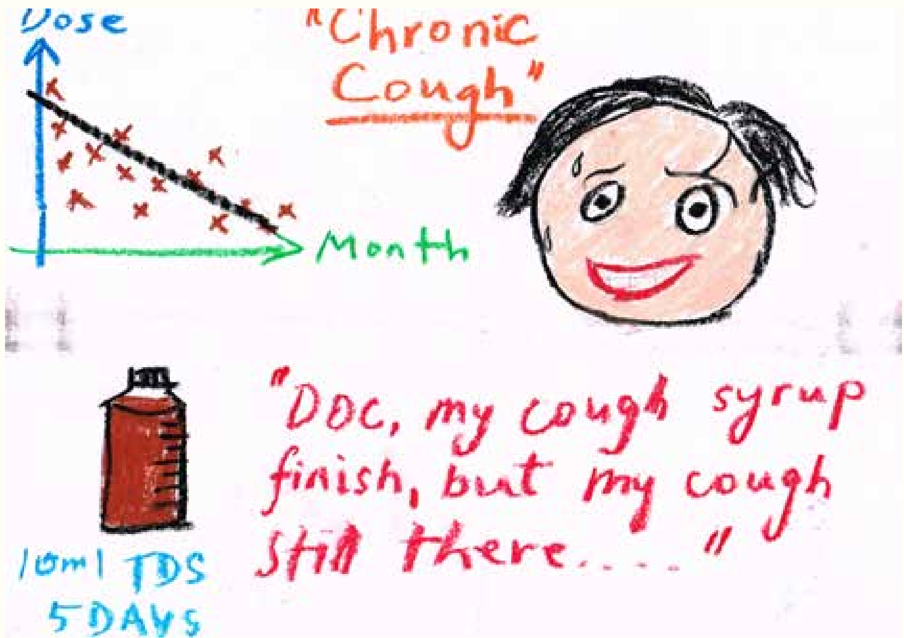
When we are in practice long enough, we may see fit to add another cause to our algorithm. We may realise that some patients may develop a dependence on codeine-containing cough mixtures. The cough is not the real problem any more. Other addictions may also surface during the consultation. Drug addicts may seek such preparations to take the edge off their withdrawal from harder drugs, or use them to mask the results of their urine tests.

In the drawing we see a young patient with what appears to be a forced smile. Is this someone with something to hide? The chart in the background illustrates the pattern of his cough mixture consumption. Is the patient here for more of the same today?

A good index of suspicion and astute exploration of the person's ideas and expectations are vital if we are to detect such problems and address them. Even then, management is not necessarily satisfactory.

— Dr. Suraj Kumar

*Many doctors find it useful to think about broad sets of problems when we see patients under conditions of pressure and speed. An algorithm helps us to deal rapidly with common presentations in a systematic way.



My Cough is Terrible!

Mr N was a thirty-year-old technician who saw me a for a cough that wouldn't settle. Over the past few months, he had seen doctors at various clinics with no apparent relief. A recent chest x-ray was reportedly normal and he had not found the mixtures, inhalers, and sprays very useful.

Today was no different. *Doctor, my cough is getting worse and I can't sleep. I need a really strong cough mixture. Can I have the black one that makes me sleepy? That one works well for me – the others can't make it.*

He was reluctant to talk about his personal life but it appeared that he may have had some family as well as work stresses.

When I offered alternatives to the black cough mixture, he became a little agitated, reiterated that nothing else worked, and declined the treatment. He did not come to our clinic again.

— Dr. Suraj Kumar

THE CURSE OF THE BLESSED

There is no magic cure, no making it all go away forever. There are only small steps upward; an easier day, an unexpected laugh, a mirror that doesn't matter anymore.

— Laurie Halse Anderson

Commentary

Anorexia nervosa is a complex and serious disease that is often reported to have the highest mortality among all psychiatric disorders. The premature and tragic death of Karen Carpenter in 1983 propelled the disease into the forefront of public awareness. It has been called the *curse of the blessed,* since many of those who have fallen prey to it tend to have been the most talented and accomplished amongst us.

Frequently, it is the family members of patients with anorexia nervosa who have concerns about their weight loss and persuade them to seek medical attention. The first port of call is usually the primary care doctor.

The primary care clinic is often crowded, multi-faceted and faceless, almost always short and sharp. With anorexia nervosa, making the diagnosis is only the initial step of a long and arduous journey. I find myself wondering how equipped we are to support our patients and their families in their journey to overcoming anorexia nervosa and other eating disorders.

— Dr. Tung Yew Cheong

Utterly Powerless

When she joined my clinic on staff five years ago, she was already noticeably thin. Her clothes looked oversized on her petite frame. But what she lacked in weight, she more than made up in her sincerity in helping patients and colleagues.

I caught a glimpse of her one afternoon during the course of a busy clinic day. She did not look well and appeared even thinner than before. I made a mental note to speak to her supervisor, and was subsequently informed that she was already seeing her own psychiatrist. Six months after that encounter, we were informed that she had been hospitalised. Another six weeks later, following several hospital visits and multiple communications, I was standing with my colleagues in the medical intensive care unit, watching her take her last breath at the age of twenty-eight.

— Dr. Tung Yew Cheong

TRAUMATIC INJURIES

Medical emergencies can happen anywhere, and when they happen in the community, the primary care provider is sometimes best placed to provide the immediate care required.

Commentary

While we may sometimes view primary care as consisting mostly of chronic disease management and treating coughs and colds, medical emergencies can and do present for management.

Over years of working in a polyclinic, my colleagues and I have attended to acute asthma attacks and myocardial infarctions. We have also encountered trauma situations, such as when road traffic accidents occur in the vicinity of the clinic. I recollect the dramatic episode of a severed hand successfully re-attached in the accompanying vignette. A picture drawn by medical students depicts another case of a chopped-off finger.

When we practise in a clinic, we have an ethical obligation to be able to respond to, and to manage patients in emergency situations. Under the Private Hospitals and Medical Clinics Act, the clinic must have resuscitation facilities for emergencies and adverse reactions to any form of treatment provided, the means to set up an intravenous infusion, and the means to maintain a clear airway.

When attending to an emergency situation, remain calm and recall your training, and call for help early if you need it. And, as with all other medical encounters, we need timely and detailed notes of our findings and treatment.

— Dr. Choong Shoon Thai

Table of Contents

A Hand In Time

I was called to the emergency room of the clinic to attend to a case of "hand amputation". The patient's hand had been cut off above the wrist and the ends of his radius and ulna bones could be clearly seen. The cleanness of the cut meant the blood vessels were well-constricted with remarkably little bleeding.

I instituted first aid measures and called for help from my colleagues at the same time. We learned from the patient that he had been attacked nearby by someone wielding a *parang**. In the aftermath, he had escaped to our clinic, leaving his severed hand behind.
The success of reattachment surgery depends on the hand being kept cool, and on the surgery being performed as soon as possible. Time was critical, and I did not want the ambulance to take the patient to the hospital without his hand!

Leaving the patient with my colleagues, I followed the trail of blood. The amputated hand was lying on the pavement beside the main road, some three hundred metres from the clinic. We wrapped the hand in gauze moistened with saline and placed it into a clean plastic bag inside a cooler box with ice, and it accompanied the patient to hospital in the ambulance.

We learnt later that the hand had been successfully replanted.

*A *parang* is a large knife is a large knife with a long and heavy hatchet-like blade.

— Dr. Choong Shoon Thai

MIGRANT WORKERS

There is a large community of migrant workers in Singapore who are employed in manual labour. Besides work-related injuries and physical illnesses, these workers also face psychosocial problems working in a foreign land. A group of local doctors and other like-minded individuals founded HealthServe in 2006 to contribute to their well-being.*

*HealthServe is a non-profit organisation providing low-cost medical care and support to migrant workers in Singapore.

Good Employers

The drawing depicts some psychosocial problems faced by migrant workers who are injured at work or who are taken ill. A migrant worker sits in a wheelchair after treatment at the Emergency Department. He is worried about the cost of treatment and loss of income resulting from his injury, as this will impact the amount of money he is able to send home.

We sometimes hear stories of irresponsible employers. However, there are also caring employers who take good care of their workers. Here are two personal experiences.

I saw an Indian worker one evening in the Emergency Department. He had just begun working in Singapore when he suddenly experienced some neurological symptoms. He was more worried about the cost of hospital admission and neurological imaging than about his illness. I was pleasantly surprised to see his employer arrive, and without hesitation assure him that the company would foot the bill for the hospital stay and treatment.

Another worker from China had worked in Singapore previously, and was now referred for a new pre-employment test. After his last Singapore stint, he had returned to China, and had been doing well, handling large government projects in his city. He had now returned to Singapore when his previous employer had requested his help. When probed for the reason, he cited his friendship with his employer.

These encounters remind me of the importance of being compassionate, restraining my prejudices, exercising empathy, and respecting migrant workers as fellow human beings.

— Dr. Loh Cheng

Behind the Label

One day I was working at the HealthServe clinic in Geylang and a migrant worker named Arjun* came in, looking rather lost. He asked, *Can you treat me? I have diabetes.* I replied that I could not. At that time HealthServe had a policy not to treat chronic diseases because we couldn't offer adequate follow-up. Arjun showed me a receipt from his last visit to a polyclinic. It was for $149.50 – payment for consultation ($40), diabetic counselling ($30), blood tests, and medications. He had not been able to understand what the diabetic counsellor said.

I felt very conflicted when I saw Arjun's receipt. I knew that he earned only about $20 a day, that he very likely had debts to pay off, and that he probably also had to send money home to his family. Paying $149.50 for a routine diabetes consultation would be a tremendous recurrent financial strain. I looked at him and said, *Brother, I'll treat you*. At our next Medical Committee meeting I suggested that we needed to change our chronic disease policy.

Arjun and his receipt got us started on treating patients with chronic diseases at HealthServe. We are now working on improving our clinic systems to ensure that our migrant brothers with chronic diseases get the best care possible at an affordable price.

Over time, I have got to know Arjun better. He is a bin centre worker and earns $18 a day. He supports his wife and three children, as well as his brother's family. His brother has died in a road traffic accident.

Continued on page 45

*Name has been changed.

Table of Contents

MIGRANT WORKERS

The foreign worker we speak to may not share our heath beliefs or expectations of the health system. When we begin with different assumptions, even our simplest sentences may need to be decoded.

Communicating Across Assumptions

The drawing shows us the harsh working environment of some of these workers, as they slog in inclement weather doing back-breaking work. What has kept this man going is the well-being of his family back home. He endures hardship and seeks treatment for the pain only when it becomes unbearable.

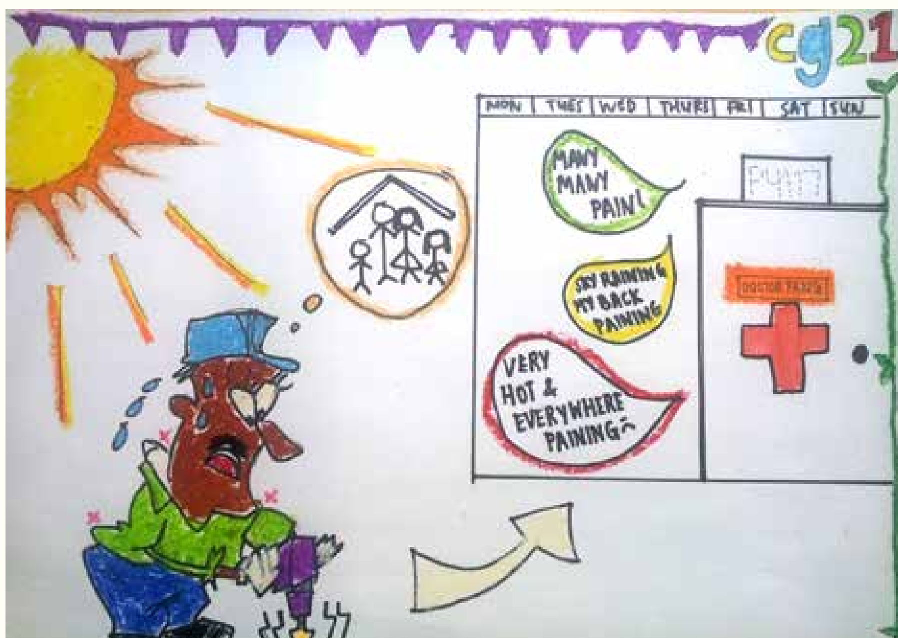
The man expresses his pain ungrammatically as *many, many pain* and in present continuous tense, *sky raining, my back paining … very hot and everywhere paining*. It is important to listen actively for the meaning behind the worker's expression, in order to understand them in their cultural context. Even then, misunderstandings can occur.

After a stint at a teaching post at a university hospital in Yunnan, China, I prided myself on my fluency in English and Mandarin. I was in a busy Emergency Department in Singapore, job-shadowing before returning to full time clinical work. I was given the task of arranging the follow-up management for a mainland Chinese worker who had sustained a bad knee contusion after falling into a drain. I was to convey the diagnosis, arrange outpatient orthopaedic follow-up, and for safety netting, include a polyclinic follow-up for extension of outpatient medical leave as needed. I thought I did a helluva job.

I was taken aback a few days later when the department received an email from a social worker seeking clarification about the two outpatient follow-up appointments. Apparently, the migrant worker was confused about being given both orthopaedic outpatient and polyclinic outpatient follow-up. Having inadequate understanding of the purpose for the polyclinic referral, he had inferred that we belittled his knee injury!

— Dr. Loh Cheng

Table of Contents



Behind the Label continued

One day Arjun had come to see me at the HealthServe clinic near closing time. I was about to leave, and I knew that I would be driving near where he lived, so I offered him a ride. He thanked me throughout the journey; he was so thankful that he had saved a two-dollar MRT fare. I asked him to show me exactly where I could drop him off. He directed me to a bin centre – that was where he lived.

I asked, *Can I visit your house?*, so he brought me in. It is the most horrendous thing to live inside a bin centre! I walked past the wet-trash compacting machine and it smelt awful. I went into a room with four mattresses on the floor, two refrigerators, and two washing machines that had been salvaged. He told me that he worked twelve hours a day from six to six.

He introduced me to one of the three friends who share his room and to a different world. He was proud to show me his room in the bin centre. I was privileged to be invited to his personal space. It helped me understand the context in which he worked and lived, and it reminded me why I had to persuade the Medical Committee to change our policy and start treating migrant workers with chronic conditions.

— Dr. Goh Wei Leong

Table of Contents

FOREIGN DOMESTIC WORKERS

In 2017, there were 240,000 foreign domestic workers, or FDWs, in Singapore. FDWs are required to see doctors for pre-employment checks and subsequently, for periodic screening for pregnancy and for certain infectious diseases. Naturally, they also see doctors for medical treatment.

Pregnancies

Work permits for FDWs can get cancelled if they get pregnant. Therefore, pregnancy detected during a periodic pregnancy screening becomes a significant problem. Pregnancy termination in an FDW is often shrouded in secrecy for fear of undesired reactions from her partner, family, friends, employer, and agent. This puts immense pressure on the FDW to deal with negative emotions completely in isolation.

The drawing shows a weeping woman with one hand on her abdomen and the other hand holding a broom with a broken handle, with a swaddled baby in the sky and black crosses near it. It could be an FDW who has just had an abortion. The baby has an antenna on its head that still communicates with her.

If this had been an unwanted pregnancy, the abortion would have brought relief. The FDW weeps because under different circumstances, her pregnancy would have brought joy. Under the terms of her employment, pregnancy is proscribed, and she has had an abortion in order to be able to continue working.

Her religion may not condone abortion. The loss of life causes feelings of grief and the fact that she has consented to this loss causes feelings of shame and guilt.

What about the father of the child? Was she pregnant by her husband before she left her home country? Has she had an affair? Was she taken advantage of by her employer?

Her despair and frustration give rise to anger and perhaps even rage, hence the broken broomstick. Nevertheless, she has to pull herself together and get on with her life, pretending that nothing has happened.

— Dr. Lily Aw

Secret Sorrows

N met a construction worker on one of her days off. Far away from home and family, she started a romantic and sexual affair with him. The sex was consensual. At her next six-monthly medical, her pregnancy test was positive.

N would not confide in her employer who she described as "very fierce". She could not tell her agent who would definitely repatriate her if he knew about her predicament. Her boyfriend refused to take responsibility for the pregnancy and even questioned whether the baby could be his. She could not go home to her husband and family with another man's child. N felt that she had been used and cast aside.

She eventually poured out her sorrows to some fellow FDWs who directed her to a clinic in Geylang and she had her pregnancy terminated there.

— Dr. Lily Aw

FOREIGN DOMESTIC WORKERS

Embarking on a life as an overseas worker… means entering a seemingly endless cycle of longing – forever reaching for your dream abroad and pining for the home you've left behind.
— Aurora Almendral

Many FDWs leave their home and their family to work in Singapore out of economic necessity.

Leaving the Children Behind

The drawing shows a woman cuddling a baby, with tears streaming down her face. The woman is probably the child's mother. Her bags are packed and there is an airplane in the background. This is a FDW going to work in a foreign land, leaving her young child behind.

For many people in developing countries, working abroad provides an opportunity to earn much more than they would earn at home, and therefore affords them the possibility of lifting their families out of poverty.

No mother would choose to leave a helpless child behind if she could do otherwise. This woman is leaving her baby and heading to a strange new family, a different culture, and an uncertain community in a foreign land.

Will her child be well? Would the baby know her after two years? Will her husband take on a mistress? Will the money she sends home be wisely spent? Will she be exploited by her agent or her employer?

— Dr. Lily Aw

Table of Contents

Home Away from Home?

The Humanitarian Organisation for Migration Economics, a voluntary welfare organisation, has studied FDW psychosocial well-being and published the results in *Home sweet home? Work, life and well-being of foreign domestic workers in Singapore* in March 2015.

Several points from the executive summary are sobering reminders of the strain many of them feel they live under. For example, FDWs work an average of thirteen hours a day, and forty percent do not have a weekly day off. For over half of the FDWs, their passports are kept in "safekeeping" by their employers. Almost a third of the FDWs have had their employers searching their room, their belongings, or their cellphone records. Almost three-quarters of FDWs have experienced restrictions on telephone calls that they can make, or restrictions to the people they may talk to, and also restrictions on their physical movements around the home and neighbourhood.

These are not easy conditions to work in, and are even more onerous if one is in unfamiliar surroundings, working for exacting employers that one may not be able to communicate smoothly with.

THE PLAGUE OF EPIDEMICS

The word "plague" originally referred to the epidemic caused by Yersina pestis-infected rodents. Today we use it generically to refer to the widespread fear and suffering beyond the biomedical, caused by serious infectious disease epidemics.

Albert Camus describes an entire city ravaged in The Plague. *Such was the social calamity caused by bubonic plague in the ancient world. Microbes have the power to disrupt society and civilization, far beyond causing diseases in the human body. In Singapore, we saw such far-reaching dread during the Severe Acute Respiratory Syndrome, better known as SARS, epidemic.*

Commentary

The medical students draw the Zika virus as an affliction of the heart and not the brain. This despite the fact that Zika wreaks its greatest damage by affecting the brain development of the unborn child. The students see that the impact of dreaded illnesses is greatest on the psyche.

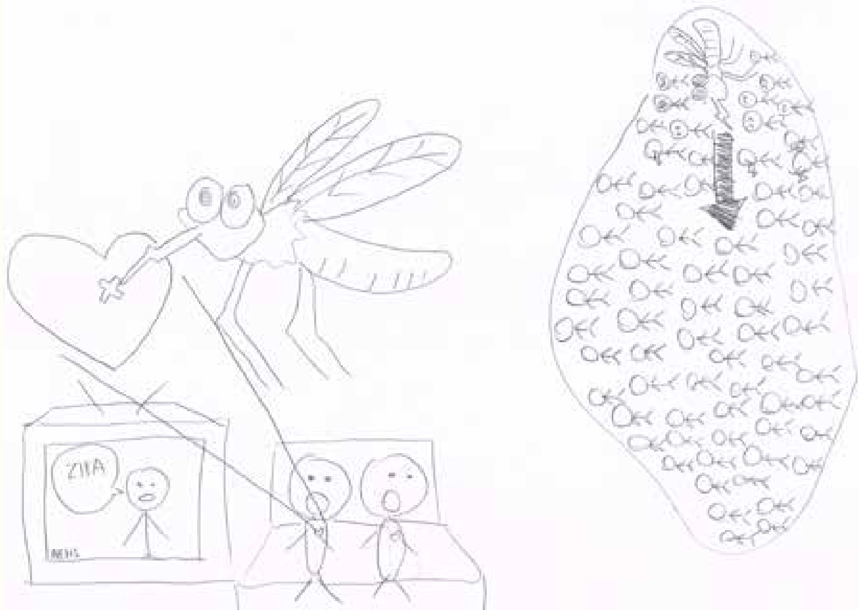
The limited Zika outbreak in 2016 was quite unlike the SARS epidemic in 2003. SARS is transmitted by a virus that spreads through body fluids, chiefly respiratory droplets. It ravaged Singapore for five months in 2003, infected two hundred and thirty-eight people and killed thirty-three. Initially confined to hospitals, it created widespread panic and disruption when it broke into the community.

SARS is a influenza-like illness, common in primary care. The vignette describes the defence of the trenches. Ultimately, trust in one another and in the leaders, along with unflinching professional commitment, ensured that care of patients continued and the virus was contained.

It is the collective human spirit that triumphs over deadly microbes on the march, not just medicine, and not just technology.

— A/Prof Cheong Pak Yean

Table of Contents



Defending the Trenches From SARS

SARS advisories, crafted by a network of all primary care providers, was the antidote against ignorance and fear. A telephone hotline was set up for information dissemination and counselling by peers, as well as the SARS Webcast by clinical leaders and experts, which allowed updates without human interaction.

Personal protective equipment was provided along with clear protocols in clinics to triage patients, control infection, and evacuate suspect cases to hospital.

Care continued to be provided for patients with acute illnesses, just as it was for patients with chronic diseases. Collegiality, professionalism, and trust amongst colleagues and staff became the defining weapons against the SARS virus.

— A/Prof Cheong Pak Yean

OUTBREAK!

The event made the headlines some nineteen years ago now. What an age back! Food poisoning outbreaks crop up so frequently these days that we hardly bat an eyelid anymore. However, there is a cautionary tale in every infectious disease outbreak.

Those who do not learn history are doomed to repeat it.
— attributed to George Santayana

A Good Day's Work

It happened in August 2000, on my thirty-fifth birthday. In the morning, I saw a few patients with symptoms of gastroenteritis, which was nothing out of the ordinary. Over lunch, my mother, who was also a doctor at our family practice, remarked that she had seen several similar cases as well. Then one of the clinic assistants complained of diarrhoea too.

It all seemed rather odd.

My immediate response was to get the staff draw up a list of patients attending for diarrhoea from that morning and also the preceding days, while I continued seeing patients in the afternoon. Still more cases of diarrhoea were seen.

When the list came out, I was startled. There were at least twenty names, and the patients all had something in common. They either lived in the condominium apartments above Bukit Timah Plaza where our clinic was located, worked in the shopping centre at the Plaza, or both. Was there an outbreak in the community, or was it confined to our building? Was this food poisoning or water poisoning? The spread of the patients suggested that it was more of the latter situation, on both counts.

How does one even report one's suspicions? Fortunately, I had some old friends to rely on. Long ago, when I served in the Preventive Medicine branch of the Medical Corps Headquarters, I had become acquainted with officials from the Ministry of the Environment's Quarantine and Epidemiology Department. A quick telephone call related my suspicions, and investigations began that very afternoon.

Continued on following page

Table of Contents

A Good Day's Work continued

Bukit Timah Plaza is an old building. The source of contamination was traced to the ageing overhead sewage pipes that had leaked into the water tanks built below them. In short, structural and maintenance issues caused the outbreak, rather than outright human error.

Over a hundred and fifty people were affected but thankfully only one was hospitalised. The most seriously affected were the food and beverage outlets, which were out of action until a clean supply of water was assured.

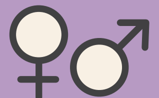
The incident highlighted the need for proper upkeep of older buildings, and also underscored the family physician's role in keeping a vigilant lookout. It was the high index of suspicion and knowing when and how to raise the alarm that led to a relatively swift conclusion to the saga.

I attended the Three Chinese Tenors Concert by the Singapore Symphony Orchestra with my wife and my mother later that evening. All in a day's work and play for a family of family physicians!

— Dr. Chang Tou Liang

Chapter Three

Family and Sexuality



WHEN LIFE CHANGES

We family physicians often toss around the phrase continuity of care almost as a badge of honour. In truth, it is a phrase that holds as much pain as it does pleasure.

Commentary

A privilege that I cherish is the chance to follow-up with a patient for many years. With a young child, or a young man or woman, I have the opportunity to watch them mature, go through their angsty, emotional years and emerge – one hopes – as happy, well-adjusted adults. With an elderly person, there is poignancy as I watch them age, and in Shakespeare's words, I witness the *last scene of all that ends this strange, eventful history… second childishness and mere oblivion… sans teeth, sans eyes, sans taste, sans everything.*

The medical students have drawn a cheerful depiction of care from womb to tomb. The accompanying vignette is a less cheerful account of care nearer the tomb.

What of the doctor? Continuing care necessarily means that the doctor is growing older, tired, and more infirm too, as the patient grows increasingly frail. We grow weary together.

— Dr. Tan Su-Ming

Table of Contents

Ninety and Up

I first met Madam T when she was seventy, attending for hypertension and diabetes, and once a year to put her thumb print on a form authorising me to make Medisave claims for her. She is now ninety.

The other day she came in on a wheelchair with her daughter. I had not seen her for some time. In the early days she would stride in on her own, a force of nature. Now she looked small and frail and a little lost, but she still seemed to recognise me.

As I reached for her hand to get her thumb print, I asked her, *How old are you this year? I am seventy,* she replied. *You must be quite hungry,* I said, knowing she had fasted overnight to do her blood tests. *Oh, not really, I've had breakfast.* Her daughter shook her head and corrected her mother. At this point I told her daughter that I couldn't take consent from mum this year because she no longer understood what was going on anymore.

I felt quite sad. I guess it was because I have known her for twenty years now. The capable matriarch I once knew, who chain-smoked, laughed throatily, ate with gusto, and always found it a thrill each year to go through this ritual with me of withdrawing money from her Medisave account, no longer had the mental capacity to do that.

— Dr. Tan Su-Ming

STILL WATERS RUN DEEP

Family violence is not routinely volunteered when we ask patients why they have come to see us. It is an issue that is carefully wrapped in other symptoms, slyly presented behind alternative narratives, and becomes an problem we did not know we were looking for.

Commentary

As family physicians we have the privilege of sharing our patients' lives as they journey through health and illness over a period of time. In spite of this familiarity, the spectre of domestic violence does not surface readily and remains off-limits in routine discussions. Victims are silent out of fear, or of emotional and financial vulnerability, or simply out of resignation.

Often, there are tell-tale signs, such as an unusual bruise, or an out-of-character request for sick leave. However, like many undeclared medical pathologies, these non-specific symptoms and early signs are challenging to recognize for the clues that they are.

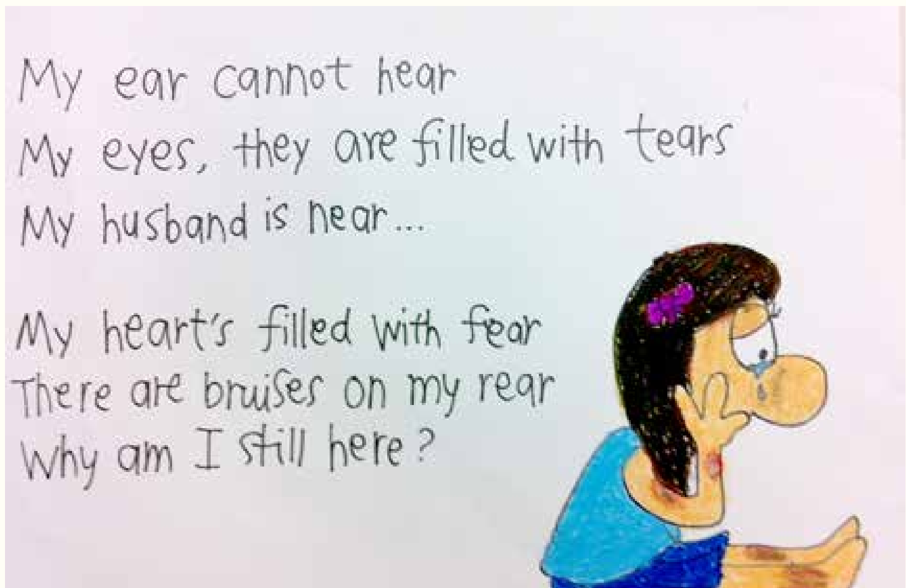
In the drawing, a woman sits quietly in the corner, a hand to her cheek and tears on her face. There are fresh bruises on her arms and her legs. The symmetry of the bruising is a harsh hint that her injuries may not be accidental.

The woman's voice comes through to us in haunting haiku. These are the child-like words of a grown woman, which are almost childish in their simplicity. Does she speak from the perspective of an established, accepted life rhythm? How does a rhythm get established except from practice and repetition, out of sight of those who could help her?

As family physicians, may we recognize the unmentioned.

— Dr. Ruth Lim

Table of Contents



Broken Wings

I remember the soft-spoken woman who was happy to share many of her significant life events with me. Over time, we talked about her children's weddings and looked at her grandchildren's photographs together. We talked through her fears of death as she cared for her ailing mother.

I thought I knew the patient and her family. A chance encounter and an unusual injury showed me otherwise. It was only then that the patient shared her darkest secret. She had endured years of verbal and physical abuse from her husband. The thought of leaving him had never crossed her mind. She was willing to tolerate, make excuses, and stay silent.

— Dr. Ruth Lim

THE INVISIBLE PROBLEM

As trite and as cliched as this sounds, we need to remember one simple lesson – life is not as simple as it seems. As healthcare providers with a special window into our patients' lives, we need to learn to be slow to judge. As fellow travellers, we need to recognise that the world can be starved of kindness.

Commentary

A woman stands defiantly, her back straight and her fists clenched. But her lowered gaze betrays the pain she must be feeling. She is occupying the central position in the composition, but there is no escaping the outline of the faceless shadow that stands behind her.

The wine glass is broken and overturned. We often associate wine glasses with celebration or pleasure, but this glass glints menacingly and is tinged with blood.

Domestic abuse can be common, but it is hard to see.

— Dr. Ruth Lim

In the accompanying vignette, Spiderman's mother assured us that she understood our instructions and knew how to administer his medications. The assurance was followed by a panicked telephone call after we had left her home, to tell us that she could not find Spiderman's medications! Eventually we had to accept that Spiderman's mother was unable to cope with caring for him at home, and arranged for admission to hospital. Even then, we only thought the mother was unreliable and in need of support, not anything more.

— Dr. Ann Toh

Table of Contents

My House of Horrors

I remember my ten-year-old home care patient. I always called him Spiderman. Spiderman was the eldest of three children, a school prefect, and chronically ill with a severe respiratory condition.

Being his doctor was frustrating. We made home visits to review and treat and support and saw his mother fail to keep on top of his treatment regimen.

I subsequently found out that, on top of caring for a terminally-ill child and two rowdy toddlers, Spiderman's mother had had to bear the brunt of domestic violence. All the home visits and the good rapport had not surfaced this issue. Life is not as simple as it seems.

— Dr. Ann Toh

FOSTERING

A child is placed in foster care when his own care structure has broken down. Fostering is meant to be a temporary arrangement, with the eventual goal of reuniting the child with his own parents. Children in foster care range from babies to teenagers, and from normal to those with special needs.

Commentary

I have family support, a good roof over my head, and financial stability. I could have been an orphan or had to grow up moving from place to place with no lasting home to call mine. I have a deep sense that I am blessed for a reason and that is to bless others.

A friend told me that in Singapore, it is not difficult to raise money and funds for those in need. But while we are materially rich, we are poor in the intangibles. *If you want to give to them,* she said, *give your time, yourself; give a supportive relationship.*

The older children and the teenagers are the ones who are most challenging to place in foster care. They have outgrown their cuteness factor and potential foster families are wary of youth with personalities of their own, no longer malleable or adaptable.

I know a couple who have recently taken in an older child with physical disability. One day, when I have finished my training, I hope that I do not forget to give as freely as others have.

— Dr. Ann Toh

Foxes Have Holes and Birds Have Nests

I know a teenager in need of a home. He is a good boy but he has no one to turn to and nowhere to go. He does well in his studies and he has a good attitude – isn't this what we want all our children to be like? He gets bullied a lot in the Boys' Home that he is at because of his gentle nature.

He is an orphan in every sense of the word. His mother, who was a foreigner, has died. He does not know his father. He was born in Singapore but has no family here. Since his mother died, he has been living in the Boys' Home, but he is reaching the age at which he will need to leave the home. Will they send him back to his mother's country?

— Dr. Ann Toh

CHILD ABUSE?

Childhood should be carefree, playing in the sun; not living a nightmare in the darkness of the soul.

— *Dave Pelzer,* A Child Called "It"

Commentary

When I was working in the home care services, we sometimes visited to investigate the home situation. There was a time we visited a woman's home to assess her coping, as she was caring for an impaired child.

On my first visit, I was truly horrified. History taking revealed that her fourteen-year-old daughter was having seizures almost every hour, was not on medication, and had not seen a doctor for many years. Was this neglect?

The girl herself was wearing a pretty, floral dress. The apartment was neatly kept. In fact, it was a welcoming, homey place, testifying to mum's efforts to create a refuge.

I probed very gently. Had there been difficulty in bringing the girl to a doctor? The woman's eyes welled with tears. Her child care leave had been used up to bring another child for visits; taking more time off would leave her jobless. She was a single parent trying to bring up six children, and she needed the job to support them all. How about extended family and relatives? Her facial expression and body language told me that this was not an available option.

It was clear through subsequent visits that there was no exploitation. She loved all her children, was trying her best, and was unaware that help was obtainable.

How many more of such families exist? Families struggling with the care of children with complex needs are sometimes barely afloat, and those with more than one ill child and facing economic hardship struggle the most.

— Dr. Ann Toh

Table of Contents

A Child Called "It"

The three-month-old boy was admitted to hospital for a respiratory illness. The senior physician picked up some hint that something was not quite right and ordered imaging. Behind his back, some of us laughed at him for being paranoid and for over-investigating. As a junior doctor, I did as I was told and organised the investigations.

We were shocked by the radiological findings. Not only did this boy have a possible leg fracture, he had also sustained a skull fracture. I scrambled to organise further cranial imaging.

The reasons the x-rays were done were so subtle that today I cannot recall exactly why we ordered them. Many of the other senior doctors at that time had questioned the need to do them.

I have now seen other such cases, many of which were picked up by school teachers. I worry that I may miss the non-accidental injury when I see a child for an unrelated illness. Yet I have also seen families torn apart by accusation when there was no real threat.

To pursue or not to pursue? This is a true conundrum.

— Dr. Ann Toh

SEXUAL BOUNDARIES

On the subject of propriety and sexual boundaries,
the 2016 Singapore Medical Council Handbook, section C4, has this to say:

…maintain propriety and take care not to breach sexual boundaries when managing patients, through inappropriate physical contact, or any sexualised behaviour of any kind … not only about avoiding inappropriate physical or genital contact… Sexual boundary breaches can occur with both male and female doctors and with male or female patients.

Commentary

Violations of sexual boundaries are serious offences even if the relationship with the patient is consensual.

The drawing depicts a surreal scene. The male doctor in the foreground has fixated his gaze on the demure, innocent-looking girl. We see flies busily buzzing around. A mysterious figure in black, with three hands, hovers in the background. One hand is preventing physical contact with the young girl, another hand is grasping a slimy green object from which the flies appear to emerge, and a third hand is around two mature women with exaggerated lips, as if readying them for the next encounter. Is the black figure a symbol of the provocation and restraint that some practitioners struggle with?

Human presence and relatedness are part of healing. The vignette reminds us that there are times the physician heals only when he is humanly present to another human in distress. Jane is asking for existential affirmation of her being human – a request that is neither sexual nor romantic. A powerful therapeutic opportunity would be lost if the doctor's response is insensitive.

Doctors need to be able to identify and navigate perceived intrusion of boundaries, and have supervisors that they can share these situations with, in order to practice safely, ethically, and therapeutically.

— A/Prof Cheong Pak Yean

Table of Contents

Doctor, Please Hug Me!

Dr Roger Than* noticed that Jane* had attended many times during the past year for various symptoms like giddiness and chest pain. Her present problem was a panic attack. Dr Than decided to ask more this visit.

Jane revealed that she had been estranged from her husband for one year. She and her husband lived together but led separate lives. They communicated via Post-It notes or cellphone texts even if they were both home. Her husband slept in the study. Jane denied depression or suicidal thoughts. Dr Than reminded her that he was always there for her, and that she should come to the clinic at any time if she ever thought of attempting suicide. Before Jane left the consultation room, she surprised Dr Than by saying, "Please hug me."

The doctor was in a quandary. To hug her risked breaching sexual boundaries. Did Jane feel that he was a surrogate? Not to hug her, or to expressly ask the female chaperone to return to witness the hug, would smack of insincerity. A discourse on ethics and boundaries would fall flat.

After a moment of awkward silence, Dr Than said, "Jane, may I ask why you made that request?" Jane answered, "For the longest time, I have felt dead. I am unworthy of human contact. What you just said touched me." "And what would you feel when I hug you?", to which Jane replied, "I would feel alive; a human being again." At this the doctor placed his hand on her shoulder and warmly shook her hand with the other.

— A/Prof Cheong Pak Yean

*Names have been changed.

SEX MATTERS

One consequence of a busy primary care practice is our contact with a multitude of people and with multiple other perspectives from our own. It is useful to pause occasionally and consider how much of what we believe to be the right thing is actually cultural conditioning.

Commentary

promiscuous
adjective
having or characterised by many transient sexual relationships.

polyamory
noun
the practice of engaging in multiple sexual relationships with the consent of all the people involved.

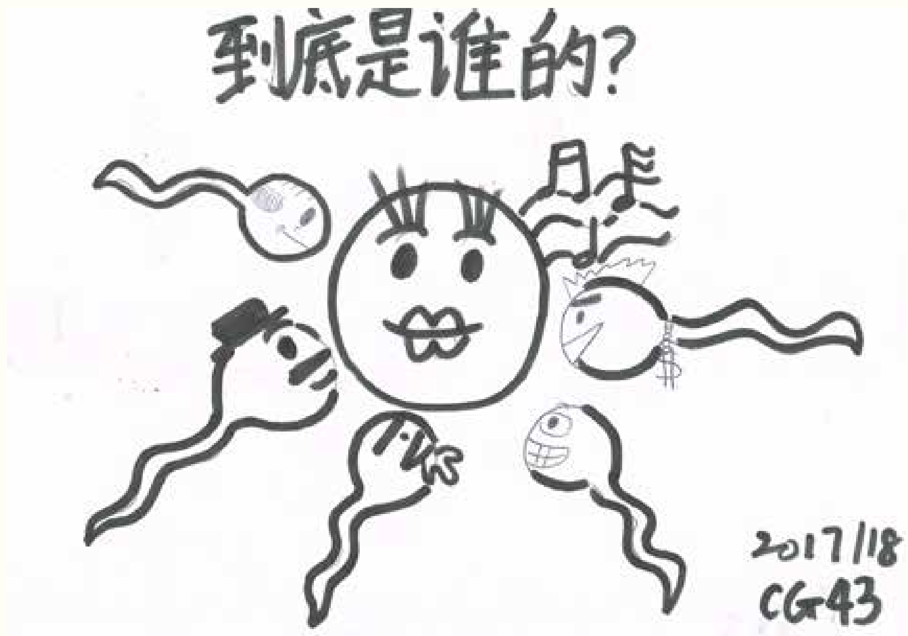
What is responsible sex? Is monogamy the responsible sex model? Yet we have unintended and unwanted pregnancies ensuing from monogamous relationships.
What is consensual sex? Is it the sex within a monogamous relationship? In that case we would not need legislation to allow a wife to sue her husband for rape.
What is a monogamous relationship? Is marriage not the most committed form of monogamous relationship? If that were the case, we should run out of affairs of the heart to gossip about.

Attitudes towards sex fall on a spectrum. Just as we have people who support freedom, there are people whose outlook we may consider to be conservative, or even timid. The accompanying vignette describes such a person.

We are the products of our culture, traditions, moral framework, values, and experiences in life. Long before we become adults, our perspectives on social order and relationships have already formed. For many of us, once formed, they become the lens through which we view the world around us.

— Dr. Angela Tan Qiuli

Table of Contents



At Last!

L was a thirty-two-year-old woman, recently married and unable to allow penile penetration during sex. Growing up in China, she did not recall any sex education, and before marriage, her mother had warned her that sex was extremely painful for the woman. Her anxiety with sexual intercourse began the day before her wedding. Every time her husband attempted to penetrate her, L had severe pain and was unable to part her legs.

Treating L involved a multidisciplinary team that included a physiotherapist and a psychologist. Various interventions spanning education, relaxation techniques, exercise and stress management, and visualisation techniques were used. It took months, but L and her husband were eventually able to successfully consummate their marriage.

— Dr. Jean-Jasmin Lee

SIZE MATTERS!

Our views, expectations, and expression of intimacy have been affected, modified, and transformed by scientific progress and technology, perhaps more so than that of any previous generation.

Commentary

Some men feel that the best way to satisfy their partner is to have good erectile function. When this does not happen, the relationship is affected.

In the drawing, the students have included a little rhyme that captures the man's hope that the little blue pill will solve his problems. We may find the words amusing, but to some men, this is a serious quest.

The zealous search for a good erection has spawned a lucrative market in creams, pills, suction devices etc., that may do more harm than good. We remember cautionary tales of men who lapsed into hypoglycaemic coma from ingesting adulterated libido boosting pills.

Has the search for a phallic triumph become the goal of a relationship? Is coitus the only way to express love and intimacy?

— Dr. Angela Tan Qiuli

Things Fall Apart

A forty-eight-year-old man had penile resection and radiotherapy for penile cancer. This was followed by a year of rehabilitative sex therapy that included psychological therapy and couple work, as he and his wife explored alternatives to traditional sex. They eventually learnt to use other erogenous zones, sex toys, and prostate stimulation to achieve orgasm.

Penetrative intercourse is only a small part of sex.

— Dr. Angela Tan Qiuli

THE SEED

We learn to take sexual history at the time we learn to take the history of presenting complaint, past medical and surgical history, social history, travel history, etc. Yet over time, when life and busyness get in the way, we tend to drop exploring whatever is not on the surface, and sometimes sexual history is the first to be dropped.

Commentary

Sex matters are a topic for whispering about rather than for open discussion.

With sexually transmitted diseases, an understandable stigma contributes to a taboo situation, where concerns about discovery are compounded by guilt and other anxieties.

Apart from the fear of catching infections, pre-marital and extra-marital sex may also carry its own other burden. The drawing on the next page depicts a couple who enjoyed themselves the previous night but are now on tenterhooks about a potential unintended pregnancy.

Even within the boundaries of traditional, sanctioned relationships, there may be social expectations and norms that affect how people feel. In the accompanying vignette, the couple is married in the eyes of the law but do not feel married in the eyes of their ancestors yet.

A side consequence of these apparently illicit activities is that the family doctor is asked for the remediation to their indiscretions. In some cases, these requests are made "by the way", wrapped up in some other more respectable reason for encounter.

— Dr. Angela Tan Qiuli

The Morning After

M was twenty-six. She had registered her marriage six months ago to K, and they had set up home in their apartment. However, they had not gone through the traditional wedding rites, and their tea ceremony was not due for another six months.

M attended because the condom had torn the night before. The last thing she and K wanted was the thought of a pregnancy before the tea ceremony. Because of this she had spent an agitated, sleepless night.

She had regular cycles and her next period was due in a week. Despite understanding that her chance of conceiving was low, it was difficult for M to stop worrying, and she wanted the morning after pill as insurance.

— Dr. Angela Tan Qiuli

SEXUALLY TRANSMITTED DISEASE

Human sexuality is a taboo topic across almost all societies and cultures. Sexually transmitted infections, or STIs, are stigmatising. The patient is unable to discuss his condition socially, in the way a patient with a heart condition can. STIs carry the stench of a socially unacceptable condition that represents punishment for forbidden sexual adventures.

Fear of discovery is compounded by guilt over the possibility of spread to others. This is a common, hidden anxiety that patients bring to STI clinics. Patients are known to over-examine their physical body, looking for signs and relating their physical symptoms to a lurking STI.

Discovered!

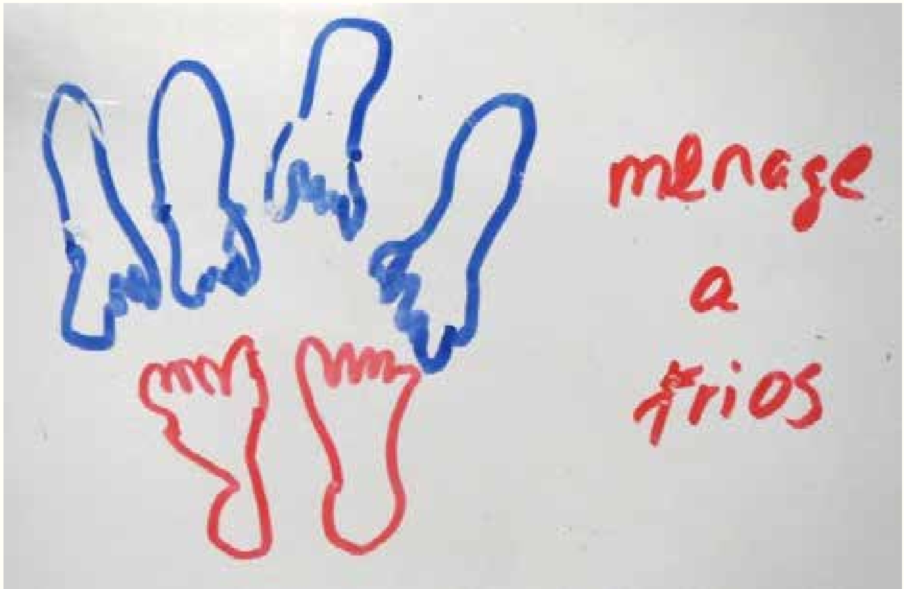
Getting an accurate history is primary. In the drawing, there are three pairs of feet, captioned *ménage à trois*, which is French for a sexual threesome. The man has painful micturition with purulent urethral discharge, but denies any sexual encounter with his wife recently, or with anyone else outside his home.

What he eventually reveals is that he has had consensual sex with his domestic helper and her female friend in his home, when his wife was out. Clearly, treating urethritis includes managing biomedical and psychosocial dimensions.

Public health issues are pertinent here. The doctor needs to advise on the epidemiological treatment of the two sexual partners. In this case, one needs to consider the legal aspect as well. As the helper is in the patient's employment, the question arises of whether the patient has broken any law, even if the intercourse was consensual and even if the helper has not complained.

— A/Prof T. Thirumoorthy

Table of Contents



Haunted by the Past

A young woman was about to marry soon. She consulted the doctor because she had detected small lumps around her introitus, which persisted even though she had vigorously scrubbed the area with Dettol.

She believed these were viral warts transmitted through sexual intercourse with different partners over the years. Hence she feared her future husband may see these lumps, and worse, get infected through her. Examination revealed that the papules she pointed to were discrete keratin papules accentuated by friction and dryness.

Despite reassurance that these were normal skin blemishes and that creams would ameliorate them, she insisted on ablative cautery. In her mind, these were concrete reminders of her past sexual encounters, and she sought medical treatment to expurgate them from her body and her mind.

— A/Prof Cheong Pak Yean

SEXUALLY TRANSMITTED DISEASE

Fear of having a sexually transmitted disease, or STI, despite adequate treatment is common. This fear may drive a patient to seek further medical treatment even though he may have no symptoms.

It is medically acceptable to treat asymptomatic patients for an STI on strong epidemiologic grounds. This may be so in cases of a high-risk sexual relationship, or when there is risk of transmitting to another partner during the incubation period, and when the patient is travelling to locations where access to good medical care is not available. Moreover, in pregnant women, sometimes the appropriate strategy is to treat prophylactically.

Replay

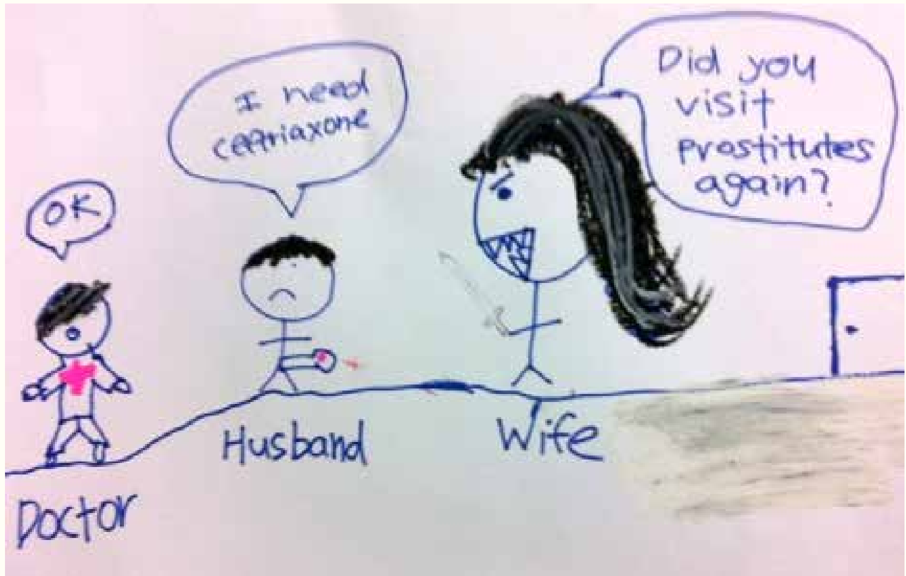
Persons who are separated from their regular partners, for example, sailors, soldiers on overseas deployment, workers in a foreign land, or long-distance drivers, are at risk of casual sex and the use of commercial sex workers. Education for STI prevention and access to condoms are good public health measures.

The drawing is about a patient who does not have clinical evidence of STI.

In this case, the fear of infection is precipitated by the foreign worker's upcoming home trip. The doctor gives the injection because of the patient's incessant pleading, as he cannot be sure that the patient has not had renewed exposure since the last episode of STI. Should the doctor give a placebo injection instead of the antibiotic? In this situation, giving a placebo may betray the trust the patient places in his doctor.

There is an additional point to make here. In patients with no clinical or laboratory features of an STI, and in the presence of strongly held beliefs that defies medical information and reassurance, we may need to assess for psychiatric issues. In STI clinics, it is not uncommon to encounter patients with anxiety with somatisation, or to uncover a latent obsessive-compulsive disorder, or monosymptomatic delusional disorder, after a causal sexual encounter.

— A/Prof T. Thirumoorthy


OK
I need ceftriaxone
Did you visit prostitutes again?
Doctor
Husband
Wife

SEXUALLY TRANSMITTED DISEASE

The management of sexually transmitted infections, or STIs, beyond the biomedical and epidemiological does not just apply to older patients. Young men and women who are confident in their immunity from serious disease are just as vulnerable to STI fears and misperceptions.

Fears and Misses

Here, the drawing captures the dread of a sexually naïve teenager who is worried that the lesions on her hands are sexually transmitted. She has engaged in heavy petting with her older boyfriend who has ejaculated onto her hands. Careful examination, blood tests, and reassurance do not avail and she is persuaded that she is ill. Unmanaged and unchecked, this discomfort can take on a life of its own and become a psychosis.

At the same time, a person may have a true STI and mistakenly attribute greater significance to it than it deserves. This may be particularly so because STI is such a prohibited topic of discussion. We only ever whisper and speculate about it, and the secrecy feeds whatever misconceptions we may already have.

— Dr. Jean-Jasmin Lee

Table of Contents

Old Terrors, New Shadows

Madam Neela* was fifty-six years old and happily married to her second husband Raj*, but their physical intimacy had greatly reduced recently. Before meeting Neela four years ago and marrying her, Raj had used prostitutes for gratification. A year ago, Raj had been diagnosed with genital herpes. To make matters worse, he had poorly controlled diabetes, and for the past year he had been afflicted with herpes attacks every month or so. Although Neela did not consciously hold Raj's past against him, she found herself wondering if he was being punished for his past transgressions. It took a multi-pronged explanation to get the couple to realise that the herpes attacks were not nature's retribution, but could be curbed with better glycaemic control and appropriate medications.

— Dr. Jean-Jasmin Lee

*Names have been changed.

TEEN PREGNANCY

In every conceivable manner, the family is the link to our past,
the bridge to our future.

— Alex Hailey

Detecting Pregnancy

A pregnancy that is unplanned or unwanted can result in many psychosocial issues, and all the more so when the pregnant woman is a teenager. These three drawings and their related vignettes traverse the three phases of teenage pregnancy – diagnosis and decision about the pregnancy, dealing with the immediate, and finally, the long-term consequences.

The drawing depicts a fourteen-year-old girl presenting with abdominal pain due to a twenty-six-weeks-along pregnancy. We are unsure if the sixteen-year-old schoolmate who accompanies her is her boyfriend, the father of her unborn child, or a trusted friend. The girl appears ignorant and lost. She seems to be most concerned about finances.

We see a faint drawing of a balance scale. Is the artist alluding to a lack of justice? The female teenager is bearing the consequences of unprotected sex whilst her male partner appears to have been spared.

The accompanying vignette describes a similar case seen by the author in a private clinic. The young couple decided to get married, and in fact went on to have another child. The clinic nurse who went out of her way to support the patient during her pregnancy deserves commendation. Unfortunately, the marriage failed, and the patient found herself alone and supporting two young children.

On reflection, was marriage the better decision, or could she have considered giving the child up for adoption?

— Dr. Ang Lai Lai

Table of Contents

Young Passion

I saw the seventeen-year-old girl with her polytechnic student boyfriend. She was a sweet-looking girl, not the defiant rebellious type we associate with promiscuous behaviour. It was her first visit to my clinic and she wanted a pregnancy test. Actually, the test was unnecessary, as she was already twenty-four weeks pregnant.

She came from a broken home. Her mother was the second wife and she had been cared for in a Girls' Home due to inadequate home supervision. My nurse took it upon herself to house her and to care for her till she delivered. The couple then brought the baby home, got married and soon had a second child.

But all did not end well. The marriage ended in divorce a few years later.

— Dr. Ang Lai Lai

TEEN PREGNANCY

…teens are not emotionally or mentally ready to be parents.
So one baby born to a teen mum is still one too many.

— Dr. Carol Balhetchet

The Psychosocial Conundrum

In the drawing the question is asked, *why (did you) not use condom(s)?*, rather than, *why did you engage in premarital sex?* The girl looks young, with her hair in pony tails and hair band and in what looks like her school uniform, and she looks despondent. The woman with her is older. Could she be a counsellor or a teacher? There is an angry face in the thought bubble. Is that the face that of the girl-child or of her parent?

The pregnant girl has an entire suitcase full of emotions ranging from fear of her parents' reaction, to their disappointment and anger, her shame, and her worries about finances. She is crying and begging for forgiveness and hoping for acceptance. Meanwhile, the sun shines and life goes on.

In some societies, young brides and teenaged mothers are not uncommon. Is mental readiness for motherhood a perception, or is it a physiological event?

The young woman in the vignette decided to terminate the pregnancy. Although the abortion had no medical sequelae, she went through a psychological crisis and it took her many years to close that painful chapter of her life.

— Dr. Ang Lai Lai

Table of Contents

Scars

I remember my twenty-year-old patient, a quiet undergraduate and a self-professed introvert. She was the adopted child of an older unmarried woman.

One day, she came to my clinic because she had missed her period. The pregnancy test was positive and I let her think through what she wanted to do with her unplanned pregnancy. She decided to have a termination of pregnancy in spite of her religious beliefs. I accompanied her to the gynaecologist.

After the procedure, she sent me a thank you card and a ceramic plaque inscribed with the words *A real friend is one who walks in when the rest of the world walks out*. She also stopped attending my clinic after that. Perhaps she did not want to remember her past.

A few years later, she returned to tell me that she had become a teacher and was in a new relationship. She had come to let me know that she had moved on.

— Dr. Ang Lai Lai

TEEN PREGNANCY

Going by the combined number of live births and abortions registered to teenaged women, the total number of teen pregnancies has declined from 1,622 in 2005 to 747 in 2016. The corresponding numbers of live births to women below 19 years for those years are 343 and 404.

Social workers believe the declining number of pregnancies results from a better knowledge of contraception. The larger number of pregnant teenaged women who go on to deliver may reflect greater acceptance of single mums and better support during pregnancy and beyond.

My Sister, My Daughter

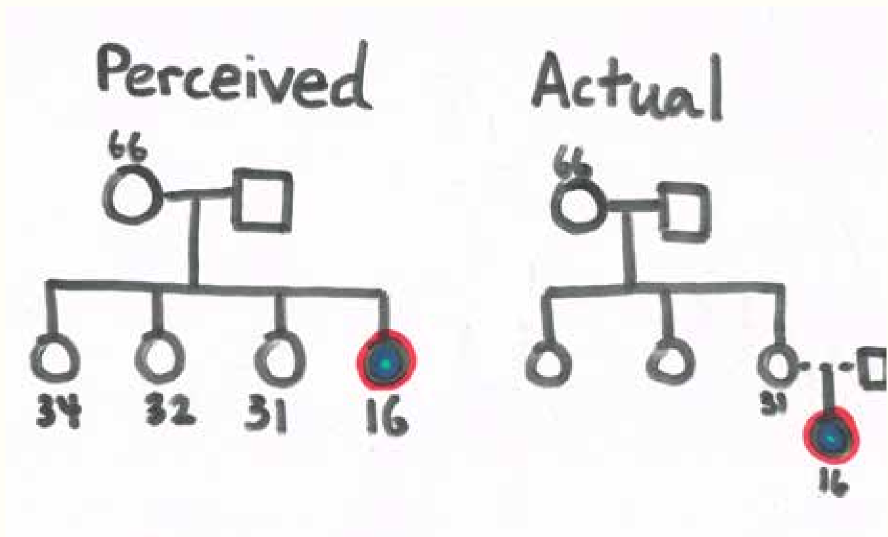
Through the clever use of the two genograms, the medical students document a baby born out of wedlock to a sixteen-year-old girl, adopted by the mother's parents, and brought up as their daughter instead of granddaughter. The grandparents become the adoptive parents, and the mother becomes the child's sister.

The students envision a scenario where the young girl keeps the pregnancy because it is too advanced for termination. She receives forgiveness and acceptance from her family and, after a hiatus, continues with her life without the stigma of being an unmarried mother. At the same time, her child is brought up by her loving parents and remains in close contact.

Diagnosing pregnancy is straightforward. Managing a pregnant teenager requires the involvement of gynaecologist, obstetrician, social worker and the family. The family doctor can play an integrating role.

— Dr. Ang Lai Lai

Table of Contents



On Diagnosing A Teen Pregnancy

What is the doctor's responsibility upon making a diagnosis of pregnancy in a teenager?

Pregnancies in women fifteen years old and younger are considered high risk, and should be referred to an obstetrician.

In Singapore, the legal age to have sex is sixteen years. This means that sex with persons below the age of sixteen years is punishable, according to Section 376A of the Penal Code.

Additionally, under Section 375 of the Penal Code, a man will be guilty of rape if he has vaginal sex with any girl younger than fourteen years.

The doctor has a duty to make a police report.

— Dr. Ang Lai Lai

WHO ARE YOU?

When I started work as a doctor at twenty-four, my view of sexuality was: heterosexual, homosexual, or bisexual. As for gender, you were either a boy or a girl. And my conservative and religious background made me believe that homosexuality was a perversion and against nature.

Commentary

Along the way from the twenty-four-year-old me to the fifty-two-year-old me things changed. What has changed is that I have seen more, and I don't hold the same views anymore.

It's comforting to be able to pigeon-hole people. We like to know: *What are you?*

Native Americans used to recognise five different sexes, including men who thought of themselves as women, women who thought of themselves as men, and bisexuals. All this got stamped out when the Europeans arrived in the Americas.

I now think that sexuality can be fluid. I think that human beings will love who they love and be attracted to who they are attracted to. I think that we do not have to pigeon-hole people. I think we should live and let live.

— Dr. Tan Su-Ming

A Boy Named Chantal

Adam always insists on being called Chantal, so that is how my clinic staff and I address him. I have known Chantal for ten years; he is now thirty-six years old. He comes every few months for sleep difficulties.

Chantal is a "pre-op" transsexual. He has breasts from hormonal treatment from various sources, but he has not had the funds or, I suspect, the complete resolve, to have the surgery that will complete his change.

I have seen him high from a relationship with a new man, and in despair over a breakup, when he goes back to his grandmother's home. He is estranged from his parents.

Yesterday, Chantal came to my clinic after another quarrel with his boyfriend. "I've had it with men!" he said. "I'm going back to women."

"Wow," I said. "Are you going back to being a man?" "I'm going to be a lesbian!"

I wanted to say, but you're a boy. But I held my tongue because I know that everyone is looking for love and acceptance. Chantal just has a harder time than most of us.

— Dr. Tan Su-Ming

GENDER IDENTITY

What is more difficult? Accepting your child for what they are or burying them because you couldn't?

— Anonymous

Commentary

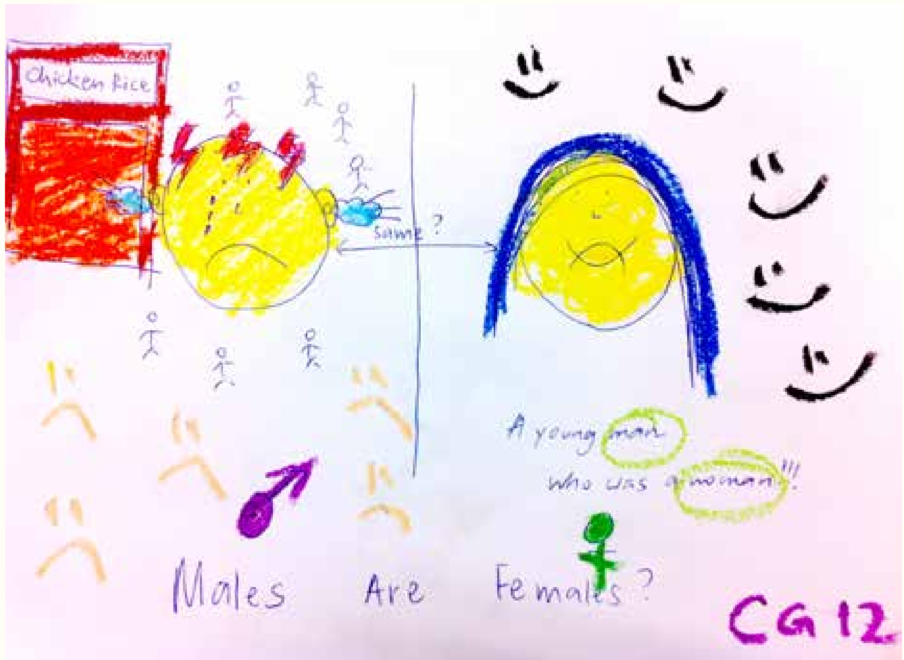
Being gender diverse is not a mental health problem. However, children and teenagers with gender identity issues often have mental health concerns, evidenced by higher rates of depression, anxiety, self-harm, and suicide attempts. A supportive family and school environment can help protect young people and improve mental health outcomes.

The picture shows the inner turmoil of a young man trapped in his biological body, and the peace, happiness, and triumph over fear when he is a "woman". This pretty much sums up what people with gender dysphoria feel. They are not becoming another person. They are already who they are. They just want their body to reflect what they have always been.

I can't help thinking that in situations such as Alvin's, acceptance must come from parents first. Among the many sources of tension and distress between Alvin and his parents, the fact that he may not fit society's – and his family's – expectations for his assigned gender is perhaps the greatest, and hardest to accept.

— Dr. D. Gowri

Table of Contents



Alvin

Alvin was a shy sixteen-year-old. I had been his family doctor all his life. His mother brought him one day, saying *doctor, something is wrong with his mind.* What followed was a long conversation with Alvin alone.

Alvin described a long-standing, intense dislike of the physical signs of his maleness and an instinctive comfort in the gender role of a female. His friends thought he was queer and he felt low, frustrated, and anxious. His school performance had suffered and his parents were at their wits' end when his mother brought him to me.

His mother did not accept my provisional diagnosis of gender dysphoria, but she eventually agreed to my referring her son to the psychiatrist. As he left my room, Alvin turned back, gave me a swift smile and said, *thank you so much.*

— Dr. D. Gowri

STILL FAMILY

Marriage is, by and large, a contract between two consenting individuals. People marry for legal, social, emotional, financial, or religious reasons. Increasingly, the marrying individuals may be of different ethnic groups or different nationalities. The contract can be an arranged one. Most marriages are monogamous although some cultures and religions permit polygamy.

Up until recently, legal frameworks ensured that marriage occurred between a man and a woman. Of course, this is changing. As of January 2019, over twenty countries recognise and allow same-sex marriages.

Commentary

Same-sex relationships are frowned upon in our society. Famously, homosexual sex between consenting men is criminal, although the law is not enforced. Same-sex marriage is not recognised. That said, many same-sex couples are living together openly as spouses in a committed relationship.

One such male homosexual couple made the news recently. One of the partners was trying to legally adopt his biological child, born overseas of a surrogate mother. In a landmark ruling, the High Court allowed the adoption to proceed.

As physicians we may need to deal with these new family units sooner than many other people. Members of non-traditional families face all the traditional health challenges that require our care. Not only that, because same-sex relationships are almost unthinkable in conservative Singapore, extended family members may face additional stresses too. The vignette describes such a family member.

— Dr. Matthew Ng

Table of Contents

Tempest

Madam K was in her sixties, just one of the many patients waiting to see the doctor. She had diabetes, hypertension, and dyslipidaemia. She lived with her three adult daughters in a five-room flat. Her husband had died years ago from nasopharyngeal cancer. Things were stable at home.

Three years ago, her oldest daughter brought her female partner home to live. Seeing this, her youngest daughter brought her partner home as well. This partner also turned out to be female. Madam K was horrified and devastated. The tensions eventually lessened when she realised that her daughters' partners treated her respectfully and well. Her middle daughter married and had a baby, whom Madam K helped look after. Things improved at home.

These days, Madam K has found some peace. She treats her daughters' partners as two additional daughters in the home. Her daughter continues to drive her to her clinic appointments. Things appear to be at a new stable.

— Dr. Matthew Ng

Chapter Four

Being Human

THE GIRL AND THE DOLL

People with deformities and people who are unusually good looking tend to stand out from the rest of us. We tend to stare at such people.

Commentary

What do you say when people stare at you?
You say, "Hello!"

A group of medical students overhear a conversation between a young girl and her mother and this inspires the attached drawing.

The girl is holding the doll, with mum standing just behind her. It is unclear who is asking the question. Is the mother questioning her daughter who has the deformed right face? Or is the girl herself talking to the doll with the pretty face, and the doll "replying" in self-talk?

Many people with body deformities are conscious of their body image and may feel that others are looking at their defect. They may develop a low self-esteem and seek physical and social isolation. This mother may be coaching her daughter to disarm onlookers with a friendly gesture. The girl may be engaging in play to project psychological problems onto her doll.

The medical students, although they are bystanders, feel a gamut of emotions ranging from sadness to bewilderment as they observe this scene.

— A/Prof Cheong Pak Yean

Corridor of Terror

I remember the first time I saw a man without a leg. I was seven, visiting some family friend in the hospital.

He was in a wheelchair looking over the balcony railings at the end of the hospital corridor. I had walked down the corridor and just rounded the corner as he turned his wheelchair around and faced me.

I saw a stump where his right leg should be.

He would have seen a girl with the full display of shock, horror, and fear on her face.

It would be many years before I learnt to look past the deformity and to see that the stump was a person.

— Dr. Ong Chooi Peng

SOCIAL ISOLATION

Solitude vivifies; isolation kills.
— Joseph Roux

Social isolation and loneliness are growing realities with devastating physical, mental, and emotional consequences, but they are distinct concepts. The terms are neither synonymous nor equivalent. Social isolation is an objective state, whereas loneliness is a subjective experience.

The current theory is that social isolation triggers a primordial response (essentially, flight or fight) that leads to chronic inflammation if prolonged. Chronic inflammation then leads to a variety of negative health outcomes.

Commentary

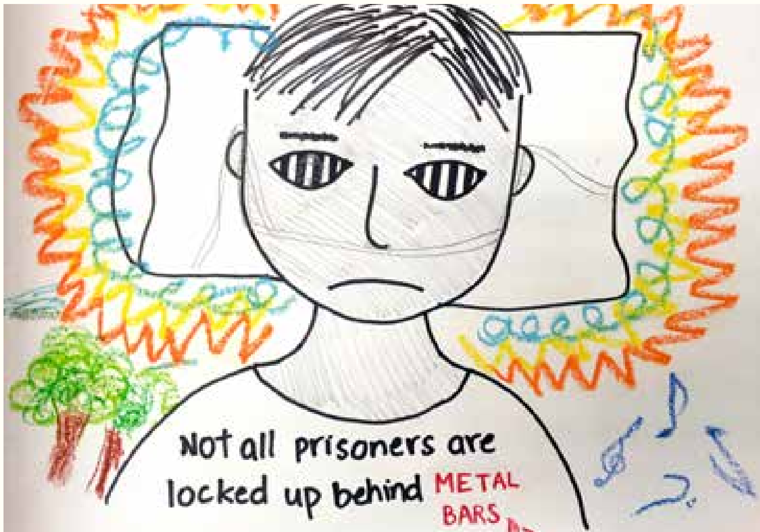
The drawing shows a listless-looking middle-aged man whose eyes are the focal point. Vertical black and white stripes depicting prison bars are drawn in lieu of normal eyes. If one looks closely at the right eye, a faded man can be seen tightly gripping the bars, his eyes squeezed shut; he looks like he is trying his hardest to escape. Is this a reflection of this man's circumstances? Is he trapped in his failing body? Instead of handcuffs or ropes, he is tied down by nasal prongs.

This man is drawn in black and white, whilst his surroundings are vibrantly coloured. Bright orange, yellow, and blue coils are drawn around his head. These brightly colored coils may be symbols of his ever-changing environment, while he himself remains stagnant. The world continues growing and brimming with life, as depicted by the trees and music symbols.

The words *Not all prisoners are locked up behind METAL BARS* are boldly emblazoned across his chest. *METAL BARS* are written in bright red. Is this symbolic of the scarlet letter of shame? Is this man ashamed that he has become a prisoner, confined and impotent? He is alone and trapped in his circumstances. His attention is turned inward. His outlook is marked by feelings of loneliness and inadequacy as he becomes increasingly isolated from life as it passes him by.

— Dr. Grace Chiang

Table of Contents



In the Midst of Plenty

Social isolation can be triggered by long-term illness, disability, lack of transportation, unemployment, or economic hardship. Isolation can mean being home-bound for a lengthy period, having no access to services or community involvement, and with little or no communication with other people. Particular attention should be paid during transitional moments – around the time of retirement, loss of loved ones, or changes in physical abilities.

Community-based interventions such as the village movement are new models aimed at decreasing social isolation. Ageing residents form an organization to provide access to services. These services, such as daily-life assistance, health programs, social events, and means of transportation, are determined by the members. This model enables older adults to make new social connections.

Technology is a double-edged sword. Technology can enhance engagement and reduce social isolation, but it can also increase social isolation. Monitoring and compensation technologies can replace human caregivers and allow individuals to live in their home despite significant functional impairment. Not unexpectedly, this might exacerbate social isolation.

Individuals, families, and communities need to work together to create and to maintain bonds.

— Dr. Grace Chiang

LONELY AND UNLOVED

Humans are a meaning-seeking species. When this experience is limited or entirely excluded, one is deprived of one's human heritage.
— Beyond Death Anxiety: Life-Affirming Death Awareness

Loneliness is different from social isolation or solitude. It arises when there is a divergence between one's desired relationships and one's actual relationships. Individuals feel disconnected, lack a sense of belonging, and are at higher risk for health problems and early mortality.

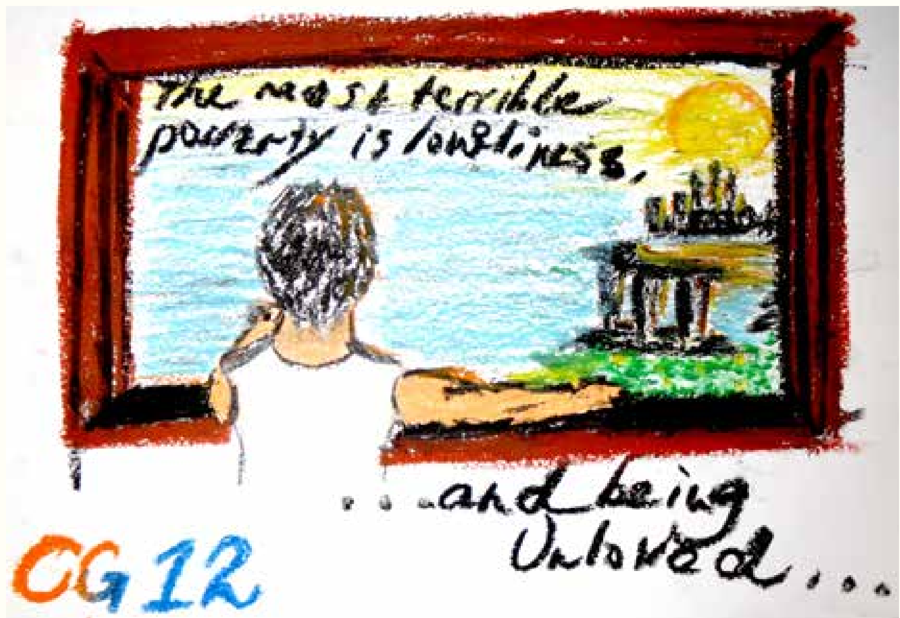
Commentary

In the drawing, the man's back is turned towards us. His expression and his emotions are not open to us. We are left to make our assumptions and to draw our conclusions from the words *The most terrible poverty is loneliness, …and being unloved…* running across the picture.

Outside the window we see successful, modern Singapore. The sun shines brightly upon Marina Bay Sands and the financial district, amidst lush greenery and blue waters. The man is separated from this impressive scene by a window. His own surroundings are sparse. His t-shirt is white, as if to blend in with the colour of the wall. His left hand is touching the window as if reaching out to the scene beyond. He is able to observe but unable to participate or to make contact. He is from the outside looking in, or rather, he is from the inside, looking out longingly, feeling unloved and lonely.

— Dr. Grace Chiang

Table of Contents



Plenty Poor

Poverty is a multifaceted concept that may encompass social, economic, and political elements. A developed and economically successful community can experience poverty in the form of loneliness. Individuals may be surrounded by plenty and feel that they have nothing.

The devastation and isolation of feeling can become a self-fulfilling prophecy. A meta-analysis studying the link between relationships and health found that individuals classified as lonely had a twenty-six percent higher risk of dying, after accounting from differences in age and health status.

Given that loneliness is quickly becoming an epidemic, some countries such as the United Kingdom have started to screen for loneliness. Social prescribing has become a buzz word – prescribing social activities rather than medications to combat loneliness.

As physicians, our treatment focus might need to shift after exploring psychosocial concerns important to our patients. By identifying loneliness, we might be better able to target interventions intended to prevent or slow the progression of functional decline and disability.

— Dr. Grace Chiang

Table of Contents

DISABILITY AND SOCIAL INCLUSION

According to the Ministry of Social and Family Development, over ten percent of the resident population fifty years and older are physically or intellectually disabled. Disability extends well beyond a person's actual limitations and can impact the emotional state, well-being, sense of self, and family, and often far beyond what we can easily identify.

Commentary

They don't friend me.

A man on a wheelchair looks longingly over the parapet, his world shrouded in a darkness that echoes his emotional state. The words shed a stark light onto his misery – *they don't friend me.*

The man watches a group of people sitting around a table. Their togetherness contrasts with the man's aloneness. Their world is colored and they are surrounded by leafy green trees. The man's wheelchair sits on hard, unyielding, gray concrete.

They don't friend me is almost infantile, a phrase more commonly associated with young children. And yet, perhaps adults think such phrases more often than we know, especially the socially isolated elderly, or the functionally impaired. By Maslow's hierarchy of needs, above our physiological and safety needs, the next level is the need for love and belonging, reflecting a universal human urgency for connection.

As healthcare workers, we are used to caring for a person's physical needs. For "functional status", we may write chair-bound or bed-bound or ADL dependent. However, we may misjudge the true import of our patient's illnesses. Has our patient lost his social circle? Perhaps he can no longer pursue a favourite hobby? Has he lost confidence and self-esteem along with his career? We need to be alert to the true impact of illnesses on one's personhood. Only then might we maintain our compassion, see beyond the illnesses, connect at a deeper level with our patients, and serve them where they are truly in need.

— A/Prof Tan Boon Yeow and Dr. Grace Lum

Table of Contents

Rebuilding Meaning

Mr. X is a forty-five-year-old man who sustained a traumatic paraplegia*. Post-accident, his world crashed. He lost not just all sensation from his waist down and the function of his legs, but also his loved ones and his vocation. His wife left him, bringing their daughter with her. He sought physical restoration by various means, including attending faith healing sessions.

He underwent extensive rehabilitation targetted not only at his physical functions, but also at helping him re-discover his role in society. Today, almost two years after his accident, he holds a driving licence for the disabled. He has returned to work as a driver who transports workers in his retro-fitted vehicle. His daughter visits him on the weekends. Most amazingly, he is representing Singapore in the international sports arena for the disabled, and has found new meaning and zest in life.

— A/Prof Tan Boon Yeow

*A traumatic paraplegia refers to paralysis of both legs following a physical accident.

IN THEIR SHOES

How often do we put ourselves in our patients' shoes?

Sometimes it is not because we do not know how to but because we do not want to. It may be that time is scarce as the consultation clock marches relentlessly, or that we dare not open a Pandora's box that may be difficult to shut.

Commentary

The drawing depicts the sombre environment that our disabled patients may live in. Need this be so? We can seek to optimise our patient's medical conditions and physical function, and also to discover what their dreams and aspirations are, in spite of their physical limitations. Some may want to play their roles more actively as parents or grandparents. Others may aspire to return to work and to contribute further to the economy.

The Third Enabling Masterplan of 2017 aims to build a more inclusive society for the disabled in Singapore. It involves four key thrusts – improving the quality of life of persons with disabilities, supporting caregivers, building the community, and creating an inclusive society. Efforts include helping employers hire and manage employees with disabilities, provisions for caregiver training grants, strengthening the use of assistive technology, and public education.

We are our disabled patients' spokespersons and advocates. Would we consider asking the next functionally challenged patient we encounter, *Hi! Would you care to share with me your dreams?*

— A/Prof Tan Boon Yeow and Dr. Grace Lum

Table of Contents

Against the Odds

Mr. K suffered a devastating stroke four years ago when he was in his early fifties. He was initially bed-bound and was fed through a nasogastric tube. His progress through rehabilitation was slow and bumpy. Two-and-a-half years after his stroke, he suffered an acute myocardial infarction.

However, Mr. K persisted and has continued to endure therapy to enhance his function. His wife is his faithful partner in this. She motivates him by encouraging him to strive to meet his aspirations.

Mr. K had always wanted to travel after his stroke.

He was a very happy man during his latest consultation as he has finally managed to fulfil his dream. He had just returned from a short trip to Thailand and had returned with a gift to thank me for encouraging him to travel. He is now looking forward to more travels in the coming year.

— A/Prof Tan Boon Yeow

TRANSITIONAL CARE

Change is situational. Transition, on the other hand, is psychological. It is… the inner reorientation or self-redefinition that you have to go through in order to incorporate any of those changes into your life.
— William Bridges

The above quote describes organisational transition, but it applies just as much to our patients' journeys from hospital back to family, community, and society. The aim of transitional care is to segue a patient from the safety of one to care and life in the other, recognising that as the team deals with the external, the patient himself is having to deal with the internal.

Commentary

Transitional care is especially vital to aid our patients with multiple morbidities and complex biopsychosocial needs as they move from an acute care setting back to their community.

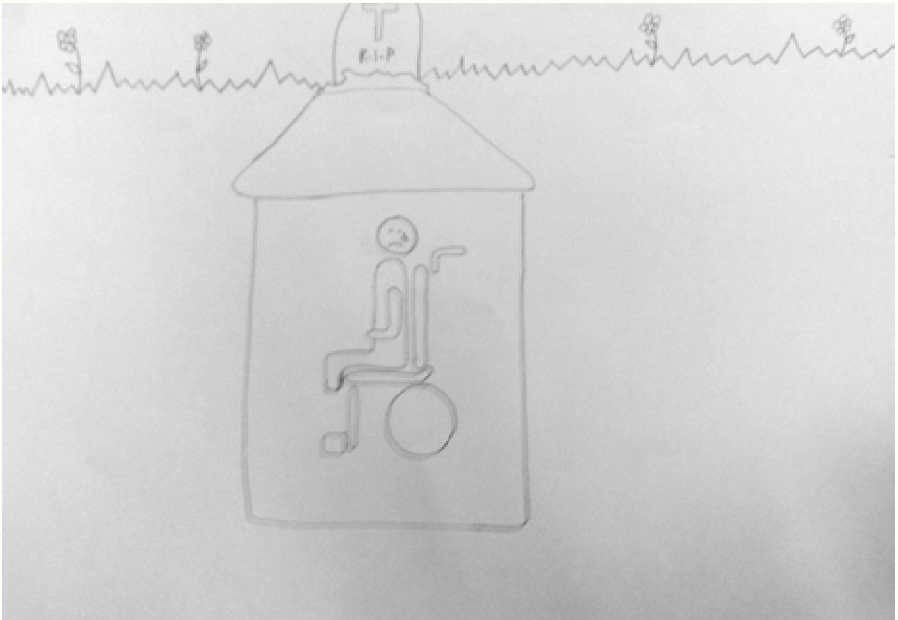
This involves medical care and equipment support, but also includes patient education, encouragement, and empowerment, and connecting the patient to various community resources. The complex patient has more than one domain of need. Therefore, good transitional care needs to be provided by a team that spans medical, nursing, allied health, and social disciplines.

In the drawing, a man who is a double amputee sits on a wheelchair in his home. However, his home is several feet underground, and there is a tombstone at ground level. He is in a living grave. The flowers bloom in the world above, which is not slowing to accommodate the man and his disabilities.

What we hope to see is another drawing, this time with the amputee patient smiling, in a home above ground, physically and emotionally linked to his surroundings. Good transitional care seeks to achieve this.

— Drs. Low Lian Leng and Tay Wei Yi

Table of Contents



Broken Pieces

Kevin* had poorly controlled diabetes. He was fifty, embittered, and grieving. He had started his journey with two gangrenous left toes that eventually ended with an above knee amputation and a sacral sore from prolonged bed rest. The transitional care team took over his care on his discharge from the acute hospital a week after his amputation.

In the following six months, we worked with Kevin on his understanding of his disease and coached him through glucose monitoring and insulin challenges. The nurses dressed his stump wound and his sacral sore. He received reminders to attend his outpatient appointments and encouragement to persist with exercises at home. We paid special attention to his mood as he coped with his life-changing loss. At six months post-amputation, he was fitted with a prosthesis and started looking for a job.

Kevin has grappled with internal demons and external beasts to get where he is. This is successful care transition.

— Drs. Low Lian Leng and Tay Wei Yi

*Name has been changed.

UNSPEAKABLE ANGUISH

Every heart knows its own bitterness.
—The Bible

Commentary

This drawing gives me a feeling of *déjà vu*. I have seen my patient with just such a look on his face.

In his right eye, the man sees himself in happier times with his family. In his left eye, all he sees is darkness. He tries to cheer himself up with glad memories of his family but he is tormented by dark memories of loss. What is he trying to say? His lips are tightly pursed. He is unable to articulate his sorrow. A lone tear is the only clue we have to his unspoken anguish.

Many patients have a happy ending and return to their families after their acute illness and hospital admission. However, there is a minority who are unable to return home due to family dynamics and social circumstances.

We are conditioned by our medical training to think in terms of pills to cure ills. For the many patients functioning within the bounds of normalcy, perhaps this may solve the issue, at least superficially. But with patients at the boundaries of function and coping, we begin to see that health and social care are so deeply intertwined that a person's well-being depends very much on both these factors being properly sorted out.

— Dr. Luke Low

Table of Contents

有苦说不出

THEY DON'T WANT ME HOME ANYMORE

It was near Christmas. Our community hospital was abuzz with festive preparations, and many patients were joining in the carolling.

Except for Mr. Tee*. Mr. Tee was an elderly man who had had a stroke some time back and recently had begun to fall rather frequently. He was in hospital for rehabilitation in order to regain his functional independence. Mr. Tee was just lying in his bed and looking at the ceiling, so I decided to sit down with him. His answers were short. *I'm tired and I just want to rest… I'm not the singing type… I've had a long day.*

A patient returned to his bed next to Mr. Tee's, accompanied by his visiting family. I saw Mr. Tee turn his eyes away from his neighbour's family and stare out the window. I decided to ask him about his family. There was no reply except for a long silence as he continued to look into the distance.

Dinner arrived at the ward and I prepared to get up and go off. Mr. Tee unexpectedly spoke then. *Isn't home food much better? Too bad I am not home.* This gave me an opening by which to engage him.

Mr. Tee told me more about his family over his dinner.

Mr. Tee had been living with his wife and his daughter's family. His wife had been looking after him since his stroke, and he had lost his pillar of physical and emotional support when she had died the previous year. This past year, he had faced increasing difficulties with self-care and ambulation.

His daughter and her family were living in his apartment, and he had recently transferred the title to the apartment to his daughter's name. His grief over losing his wife and having to be dependent on his daughter had weighed heavily upon him. In an attempt not to trouble his daughter, he had tried to do more for himself, with the resultant fall that had landed him in our hospital.

*Name has been changed.

Continued on following page

Table of Contents

They Don't Want Me Home Anymore continued

Mr. Tee was to have gone home a few days before Christmas, but his daughter and her family had decided to go abroad over Christmas. As there was no carer at home, he was forced to delay his discharge. *I feel useless. I need help from everyone. There is nothing much left for me in this world* came up repeatedly as we spoke.

We looked forward to his going home for the New Year, but he was hit by another blow when his daughter returned. His daughter did not wish to bring him home. Instead, she wanted her father to go and live in a nursing home.

Legal advice was sought with regards to his daughter's responsibility to care for him. However, as his daughter was prepared to pay for the nursing home stay, she was not abandoning him. It was just that the solution she was prepared to fund was not his desired one, which was to return home.

I remember that day when he gave up all hope of returning home and consented to admission to the nursing home. He had that look of unspeakable, indescribable anguish on his face.

— Dr. Luke Low

Table of Contents

NURSING HOME: TALES OF SORROW, TALES OF GLADNESS

To be admitted into a nursing home run by a voluntary welfare organisation, one must lack caregiving arrangements, be significantly disabled, and have few means of support. Such a nursing home is designated a voluntary nursing home, or VNH.

I think of the admission requirements as the three D's: patients do not have a carer at home, are disabled, and are dirt-poor.

Commentary

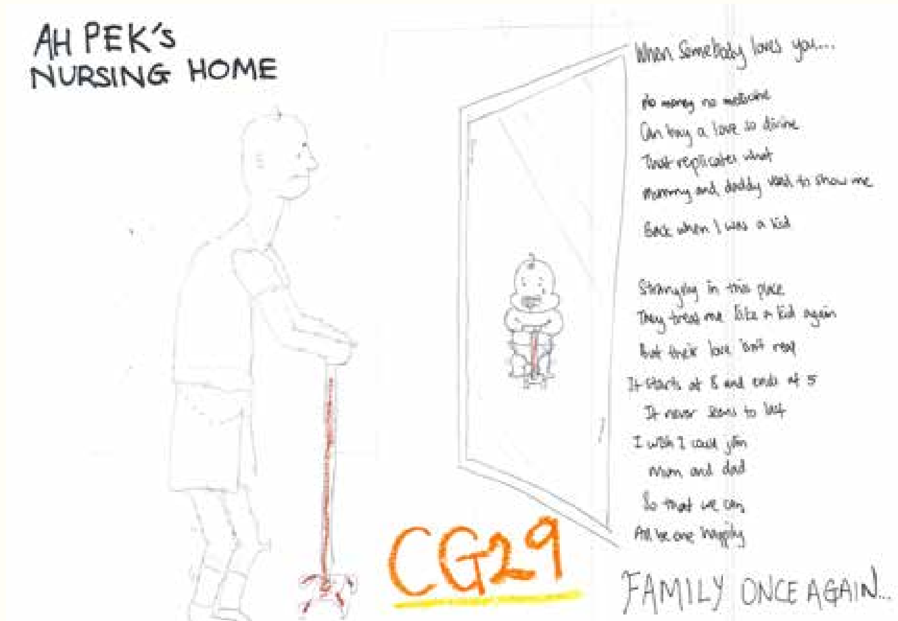
After years of working in a nursing home, I have a fourth D that describes the families of many residents: **d**ysfunctional. For a host of reasons, many of which may be long-forgotten, there are families who visit rarely, or are recalcitrantly uncontactable. The VNH may be the last port of call in a journey of strained patient-children and patient-sibling relationships. Children may have mental illnesses and other disabling problems of their own, or they may be incarcerated. Some children do not talk to one another. Some patients have been abandoned by their family.

What is a nursing home? It's a place where professional care is provided round the clock, to patients who require skilled nursing care or assistance in activities of living. An increasing number of our frail elderly are being placed in nursing homes, as a result of greater life expectancy and growing complexity of illnesses, *vis à vis* a dwindling supply of caregivers in smaller families.

Whither filial piety? Surely the ideal set-up should include co-residence by children and their ageing parents. Unfortunately, reality is sometimes not ideal. Traditional values have changed. Some families have no alternative to placing their loved one in a nursing home. Some choose the easy option.

— Dr. Marie Stella P. Cruz

Table of Contents



The Shattered Pitcher

A Chinese man in his mid-nineties admitted himself into a nursing home. A widower with five adult children, he had moved in because he did not want to "trouble" any of his children, and he had had a good impression of the nursing home years ago as a visitor. Months passed amidst the stark reality and mundane routine of the nursing home, and he increasingly desired to leave. He requested the social worker's help to arrange for him to move in with one of his children.

A family conference was called. Not one of his children, who all lived in their own properties and were financially comfortable, agreed to accept him. One child said that if the nursing home discharged him, there were nursing homes in Johor Bahru and Thailand, implying that they would simply place their father there. The old man died in the same nursing home two years later, broken-hearted.

As his family physician, I optimised his medical care, but could only empathise with him over the family drama. What I did do were little things to brighten his day: visit him regularly, to make small chat, and once, I treated him to a McDonalds breakfast, right there at his bedside.

— Dr. Marie Stella P. Cruz

NURSING HOME: TALES OF SORROW, TALES OF GLADNESS

Where are the children? For many residents, the healthcare staff become their family. For some, these are their only family.

Sorrow

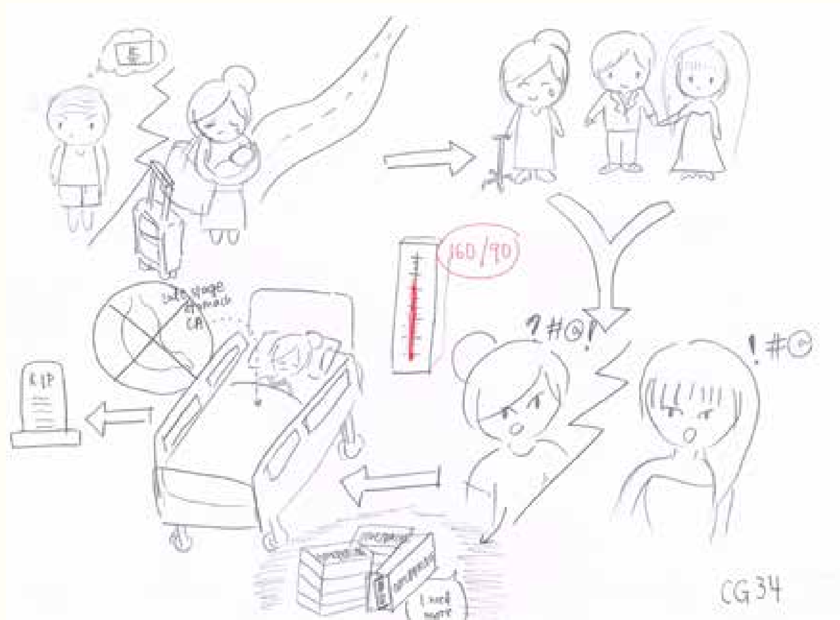
The drawing on the previous page is titled *Ah Pek's Nursing Home*. *Ah Pek* is Hokkien for *old man*, and the average age of residents is around seventy years; many are well into their eighties and nineties, and a handful are centenarians. The bent old man looks forlornly at himself in the mirror. Memories of his parents lavishing their love on the younger him come flooding back. His home is now this nursing home, and the healthcare staff have become his family. Can this compare with the "real" thing? The *Ah Pek* longs to go home, but like many of the residents, he will not have another place to call home.

The drawing in the next page shows another dysfunctional family: the husband abandons his young wife, leaving her to care for her new-born; the woman brings up her daughter who eventually gets married. Their relationship becomes strained and the daughter distances herself from her ageing mother's care, and may have even placed her in a nursing home. The mother is diagnosed with an advanced cancer and passes away, alone.

Scenarios such as these are not uncommon in nursing homes, as depicted in the real-life vignettes.

— Dr. Marie Stella P. Cruz

Table of Contents



When Love Grows Cold

A forty-five-year-old woman with two teenaged daughters suffered a haemorrhagic stroke that left her densely paralysed, wheelchair-bound, and dependent, although fortunately her cognition was unaffected. Her husband, a businessman who travels a lot, placed her in the nursing home, despite their having a helper at home; his purported intention was to bring her home after she had "recovered". Two years later, she is still in the nursing home. Her husband drops by for a quick visit once a month, and she is occasionally visited by her two daughters, who have grown distant from her. Her husband pre-empted her from contacting the family, and indeed from being linked to the world outside her six-bedded dorm, by not providing her with a cellphone.

As her family physician, I optimised her medical care, but I could only empathise with her over her family situation. What I do is to give her some of my time and company so that she can weep occasionally.

— Dr. Marie Stella P. Cruz

NURSING HOME: TALES OF SORROW, TALES OF GLADNESS

What does the nursing home aim to provide? Besides traditional provision of medical care, there are other important objectives – providing a safe and supportive environment for the chronically ill and dependent, restoring and maintaining the highest possible level of function, preserving individual autonomy, maximising quality of life and life satisfaction, and providing comfort and dignity for patients – and their loved ones – at the end of their lives.

Gladness

In the drawing, a member of the staff greets an elderly resident cheerfully, and the resident reciprocates with a heartfelt smile. It is important to highlight that the medical student was struck by this simple act of kindness and chose to record it for posterity.

This drawing is an apt tribute to nursing home staff. The staff comprise a handful of locals and majority of foreigners from nearby Asian countries, who undertake demanding work in a taxing environment for a modest wage. Many are there for years, dedicating their working lives to caring for the frailest, and getting to know their charges thoroughly, like a true family.

Apart from good environmental and activity design, it is quite fair to say that in nursing homes, the staff are the quality of life.

What happens when a resident dies? We try to have a joyous celebration of his or her life. At our mortality and morbidity meetings*, staff who have cared for a deceased patient give a eulogy, to celebrate the person and his life. Quirky behaviours, funny incidents, how the patient had been during his heyday, and stories of their families, are shared, to laughter, smiles and the occasional tear amongst those present.

The best gift we can give our residents who have left us, is to remember them in our hearts. This too, is the essence of being family.

— Dr. Marie Stella P. Cruz

*Mortality and morbidity meetings are regular meetings during which patient deaths (and other serious outcomes) are reviewed to ensure that the best care has been rendered.

Table of Contents

By Sun and Candlelight

On love that never dies, that forever endures whatever, wherever, and transcends our physical existence. A husband in his seventies, himself saddled with several chronic conditions and residing in a sheltered home, comes regularly to visit his frail wife in the nursing home. He does this thrice a week, enduring the long bus rides to and fro. He and his wife sit in a quiet corner of the balcony, where he peels grapes and plays fifties-era Chinese jazz for her on the radio. The wife's brain has been ravaged by radiotherapy for a brain tumor, followed by a stroke a few years later. She can hardly talk, but to her husband, this does not matter. I joke with them that they are on a *paktor* – Hokkien for boy-girl date – and he smiles at me sheepishly.

Enduring Grace

A son in his seventies came daily to the nursing home for months, to dress the malodorous, gangrenous foot of his centenarian mother, till she passed away. He considered dressing her foot as his filial duty, and would not allow staff to do it.

— Dr. Marie Stella P. Cruz

AT THE END OF LIFE

The mythology of Modern Medicine centres on its valiant, triumphant struggle against the diseases that threaten life. Death is the abhorred outcome and a sign that medical care has failed. We emphasise medical breakthroughs and designate less attention, training, and observation to dying and death, even though we acknowledge the universal truth of birth, ageing, sickness, and death.

The medical student, however, may not be entirely acculturated into this paradigm, and yet he may come extremely close to situations of dying and death.

Seasons in the Sun

The drawing is a fascinating portrayal of a medical student's experience with a patient's death in the hospital intensive care unit. The student is barely in the room – his backpack is still on his shoulders – when he is confronted with the scene of death. He stands, statue-like, eyes widened and mouth agape, in shock or in terror. His hair stands on end. His limply hanging arms show his utter helplessness.

To his left, two children hug themselves and look forlornly at their crying mother and dead father. The widow stands with her hands on her face, her eyes closed, presumably crying. Strangely though, tears are not drawn.

The dead man has his eyes closed and his hair dishevelled. Electrode leads connect to a machine that indicates asystole*. The attachment to the machine is the only form of connection depicted here. The human figures are not interacting with each other – the student, children, wife, and patient are spatially discrete and separate from one another. Also significantly, that medical student is the closest to a healthcare provider who is depicted in this room of grief, sorrow, and need.

At the top are the lyrics of a song that the student remembers as he enters the scene. They are from the song *Seasons in the Sun* by Terry Jacks, except that the lyrics are misquoted. Instead of it's *hard to die*, the version in the picture is *it's time to die*. Consciously or unconsciously, this appears to be an epiphany about the inevitability of death. The incongruity of death in the midst of life when all the birds are singing in the sky summarise his reaction to the experience.

— Dr. Tan Yew Seng

*Asystole refers to the flat line of death on the heart tracing.

Death's Broader Sweep

It is easy to intellectualise dying and death as a medical or pathological phenomenon. This drawing depicts what death means as a human and social experience.

The student is also a witness to the lack of care and support at the end of life, ironically when they are most needed. Has this to do with our emphasis on medical treatment and intervention? When the situation is deemed medically futile, care is rationally withdrawn and care providers leave the scene.

Do they avoid it too? It does not require much imagination to perceive the negative spiral that can come out of this situation: the more we avoid addressing the care of dying and death, the more we will create such scenes of desolation and the more healthcare providers will experience terror and helplessness, which will in turn lead to more avoidant behaviour. How do we train aspiring – and even practising – doctors for their encounters with the death of their patients? Death of patients can leave impactful memories in doctors, which may in turn affect the quality of care. It is known that there is little support to help medical students and doctors process their experiences of patient death.

— Dr. Tan Yew Seng

AT THE END OF LIFE

When we face repeated challenges at work, one way to protect ourselves emotionally is by distancing and depersonalisation. One result of depersonalisation is the eventual metamorphosis of medical student into faceless practitioner.

Pulling the Plug

The drawing is a composite of two scenes. To the right a group of doctors is huddled in discussion. They are faceless and have disproportionately huge heads with amorphous bodies. Emanating from two of the heads is a speech bubble that depicts the content of their discussion, i.e. pulling the plug. On the left side is a very ill patient with eyes closed, mouth hidden behind an oxygen mask, hairless head, and perhaps not unexpectedly, body contours demarcated with broken lines. A tear flows from his left eye, and above him the words in red *I can hear you* float without a speech bubble.

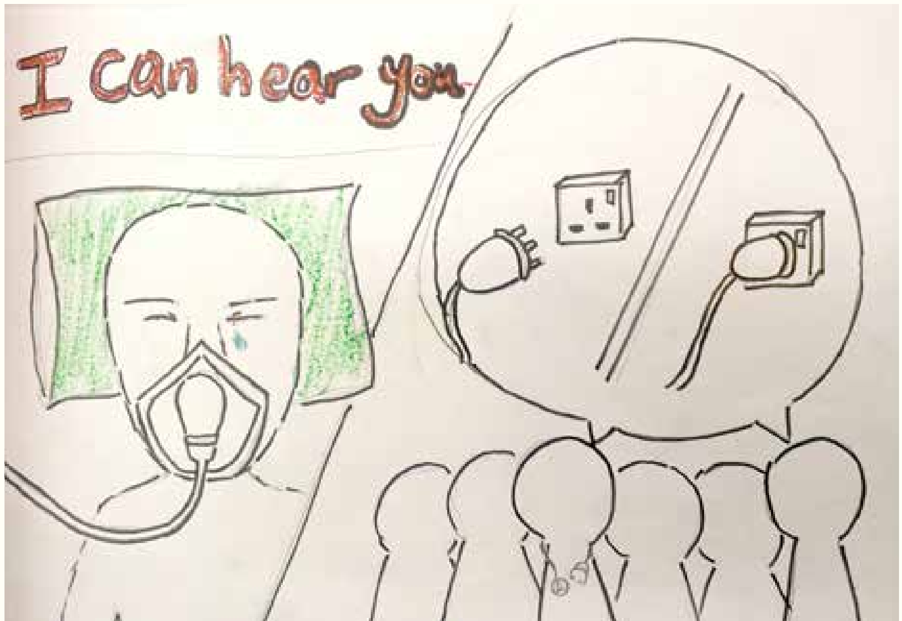
The two sides are separated by a slanting divider that imparts a dynamic tension between the scenes. The division is incomplete, being disrupted by the patient's pillow, which subtly suggests that the patient and doctors are actually in proximity. Thay are in the same time and space yet are divided.

Is this a picture of moral distress? Moral distress may be defined as a state of anguish when one encounters a moral transgression, and because of real or perceived constraints, becomes a party to the moral wrong-doing. The medical student has chanced upon a medical discussion of "pulling the plug" in the presence of a supposedly comatose patient. What catches the student's attention is the patient's tear as the doctors speak. It is unlikely the patient can speak, but the student's empathetic awareness makes him realise that the doctors' discussion is insensitive and hurtful. And yet the student probably does not protest to the doctors, and by association with the medical profession, becomes an accomplice by compliance.

Another issue that one may identify here, is the danger of regarding medicine as an intellectual process that objectifies patients, puts diseases before persons and their families, and ranks treatment over care. The outcome of such an unfortunate approach is dehumanisation, the indignity of which the student reacts to. Remember, however, that doctors were once perceptive and sensitive medical students.

— Dr. Tan Yew Seng

Table of Contents


I can hear you

AT THE END OF LIFE

An ethical confusion can descend with a patient's request for death. Healthcare workers get absorbed by their own sense of helplessness and grief as they construe themselves as the key to the solution. The hopelessness of the situation may be such that death seems like the only way to alleviate the patient's suffering. Furthermore, the ethical pillars of patient autonomy and social justice are thrown in to support that assertion.

Assisting Suicide

The drawing depicts an encounter with a sick patient requesting for a hastened death. *I can't see, I can't hear* is the despairing cry arising from incapacity, purposelessness, and almost certainly meaninglessness of the current suffering and life. Unexpectedly, the colours are remarkably cheerful. The patient's hand appears to be reaching for either the capsules or for heaven itself. Is the artist subconsciously supporting the patient's proposal?

Remember, though, that the request for death can have different meanings. It can be a cry for help, a hypothetical exit plan, or a true desire for hastened death. Even if this patient truly desires death, however, what needs to be considered is the expression of his experience that is communicated to the medical student, which may be paraphrased as, *I am suffering so much because of my incapacity, symptoms, sadness, loss of dignity… that I find little reason to live this way.*

The desire for hastened death often occurs on a background of hopelessness, depression, and unaddressed physical distress, and it may lessen with improved physical, spiritual, and personal functioning. The important question is whether we have focussed enough attention on these areas of care for our dying patients, before they descend to depths of despair.

Some say that the suffering of mortality is inevitable and intractable. How can we even attend to someone in such suffering?

— Dr. Tan Yew Seng

Table of Contents

The Cold Embrace

The only way I know that will serve a patient in the throes of mortal agony is to come alongside him, as another mortal. This involves my willingness to witness his suffering, and offering my presence and any other acts, as a fellow mortal. It involves validating his worth and dignity, regardless of his state or proximity to death.

It requires that I constantly acknowledge my position as a novice, and that the dying person and death are my teachers. To just "play doctor", we risk becoming oblivious to our patient's real suffering, or worse, bringing about death, in our haste to solve death.

— Dr. Tan Yew Seng

A DESCRIPTION OF DYING

Shan* was a woman in her late forties who was dying from metastatic breast cancer. Earlier, pain had been disabling from metastases to the mediastinum and right femur, but fortunately these symptoms had abated with treatment. As with many patients, we sensed her fear and anxiety about dying although she declined to discuss these issues.

Towards the end, Shan chose to be at home, cared for by her mother. Her last days were marked by delirium, contributed to by hepatic encephalopathy from extensive hepatic metastases.

One morning, her mother called to say that Shan was not responsive although she looked comfortable. Medically, she had come to the final stage of her life, and would probably die while in coma. But perhaps sensing the need in her tone, I decided to make a home visit anyway.

When I arrived, Shan, deeply jaundiced, was lying quite motionless and was gasping. Blood pressure was no longer recordable and her pupils were dilating. With her eyes closed, she managed to shake her head just barely perceptibly when I asked if she had pain, and nodded when I asked if she was comfortable.

Suddenly, her eyes opened wide, to the astonishment of her family who had gathered in her room. In all medical likelihood, she was on the brink of finality, and I intuitively asked the family to go to her side.

Her eyes drifted to the left where most of her family was, and her mother reaffirmed her commitment to look after Shan's young children after her death, and told her to die in peace.

Then Shan's eyes drifted towards the right. I looked around, and saw that her father, a rather reserved person in the family, was standing as usual at the edge of the group. I guided him to Shan's right, where he too, offered his farewell.

*Name has been changed

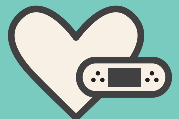
Table of Contents

After a while, her eyes drifted back to the midline with the same measured and clearly deliberate pace. She closed her eyes, and within minutes, took her last breath.

— Dr. Tan Yew Seng

Chapter Five

In Practice



THE BUSINESS OF MEDICINE

There is an inherent conflict of interest when doctors practise medicine as a business, especially in a for-profit healthcare setting.

Commentary

As doctors, we are called to the service of humanity. Unfortunately, this does not mean that we are spared the reality of having to make a decent living. This is especially pertinent in the private sector, where medical practices are businesses, dealing with increasing overheads, and with the constant possibility of economic failure.

Therefore, we need to charge a reasonable professional fee and bill patients equitably for services such as investigations and procedures. At the same time, we cannot exploit patients for monetary gain, and we need to exercise restraint in the face of commercial pressure.

The considerations involved in charging a patient underpin the perennial tension between professionalism and commercialism, and between altruism and self-interest. In primary care, the family physician is interested in developing a long-term relationship with his patient. He will not benefit if he sets his fees beyond the reach or trust of his patient.

In the drawing, the doctor's consultation fee costs three dollar signs. The magnetic resonance imaging costs the equivalent of seven dollar signs. Rising demand for the latest technological scans and other expensive tests tend to overshadow the doctor's professional assessment. This is ironic. It is the doctor's assessment that the patient should ascribe the most value to, because the doctor's clinical judgment is uniquely tailored to him as the patient.

Left unchecked, commercial interests may erode the value of a good clinician.

— Dr. Wong Tien Hua

Table of Contents

BILL

See doctor $$$
take blood $$
X-ray $
ECG $$
CT $$$
MRI $$$$$$$

Diagnosis IDIOT-pathic

WHO'S THE BOSS?

We live in an increasingly complex and converging society. Our patients are more keenly aware of their conditions, their needs, and their rights. As a fraternity, the earlier we recognize this and the more we work together to improve our outreach to them, the better we will be able to manage a more diverse and complex array of issues, with better clinical outcomes and service excellence for our patients.

Commentary

We practise and operate in a highly competitive and stressful environment. Patients are better informed and have more intricate requests than before. Payor-provider relationships vary vastly from the traditional patient-doctor compact. Social media feeds and threat of legal action compete with clinical practice guidelines to influence medical care.

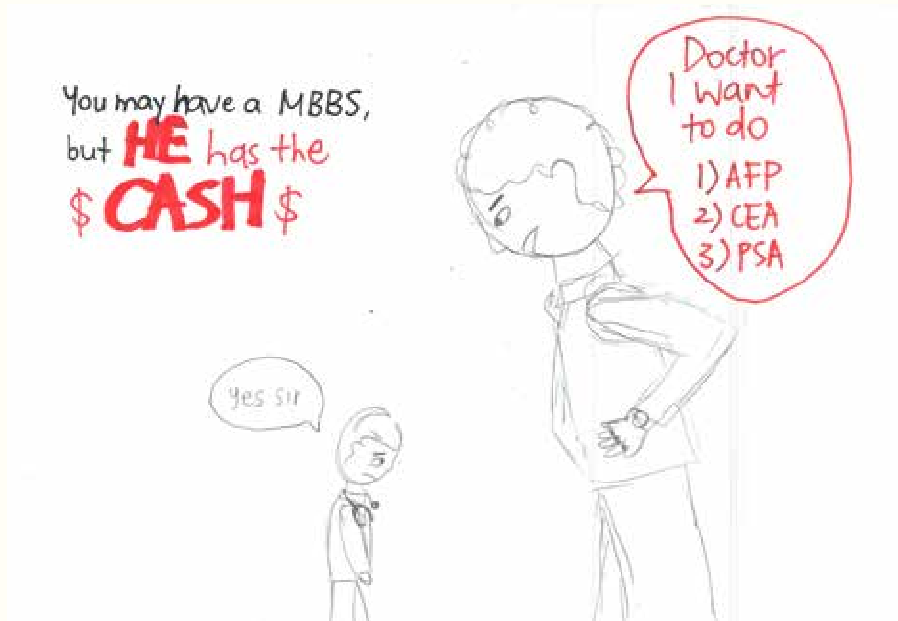
How do we soldier on and do the best for our patients? Today's primary care doctor needs more than updated knowledge and engagement in his professional community. He needs to build trust, painstakingly over time, with his colleagues and his patients. His patient base should be diversified to include different forms of care financing. And instead of resisting change, he needs to adapt to the new and innovate within it.

In the drawing, the towering figure could be the patient, his employer, or the insurer insisting on certain investigations or treatment. The doctor finds himself having to constantly choose whether or not to accede to demands with no clear medical indication, or with ambivalent medical justification, or worse – demands that put him in clear conflict with professional values and ethics.

For our healthcare system to be robust and sustainable, we need a durable tripartite relationship between doctor, patient, and payor that is built upon mutual respect and trust.

— Dr. Tan See Leng

Table of Contents



Doing Good and Beyond

I sat in on a consultation once. The patient was an elderly retiree with an acute cough that he wished evaluated with an x-ray. The young doctor sent him for an x-ray that, not unexpectedly, turned out to be normal. He also had a knee pain from mild osteoarthritis that he wished assessment for by an orthopaedic surgeon. The young doctor obliged him with a referral. He requested a supply of NSAID* for his knee pain. The young doctor protested, mentioning adverse drug reactions, but the patient insisted and prevailed. He ended with a request for a set of skin creams "for standby". The young doctor, drained by then, prescribed whatever he desired.

How does one tread the fine line between good-natured obligingness and unthinking acquiescence?

— Dr. Ong Chooi Peng

*NSAIDs are a class of pain-killers that, although effective, come with a range of side effects that make them less suitable options for elderly patients.

REGULATORY MATTERS

The central defining relationship in healthcare is that between the doctor and the patient. Regulatory efforts are aimed at safeguarding and strengthening this. And rightly so, because the ethical framework that underpins our work is founded upon a healthy doctor–patient relationship. In an environment where significant information asymmetry favours the doctor, the patient's interests must not be compromised.

Commentary

The traditional strategy to protecting patient interests has been to keep the focus on the doctor. Ethical codes, fees schedules, and various guidelines reinforce the doctor's responsibility to uphold the propriety and sanctity of the doctor-patient interaction.

However, the doctor-patient relationship is not the only material relationship in the healthcare landscape these days. Healthcare has come to involve multiple inter-connected parties that interact with one another in various ways. Many other relationships vie with the doctor-patient one as these other parties influence and direct the provision of healthcare services, and they have the capacity to alter the nature of the doctor-patient interaction significantly. Just think of the patient who has to switch to a new panel doctor when his company health coverage policy changes.

Moreover, the new compact includes more than just the officially recognised players. The old information asymmetry has, to an extent, been disrupted by the advent of WebMD and Dr. Google. These new-age doctors are additional participants who are not bound by the ethical code and who do not pay malpractice insurance.

A regulatory approach that is primarily doctor-centric ignores this new reality.

— Dr. Wong Chiang Yin

Table of Contents

Brave New World

Many of the new players in the healthcare landscape are not regulated as healthcare entities. These include managed care companies, third-party administrators, medical concierge services, and even web-based companies that offer doctor-searching, doctor-ranking, and appointment-making services. On scrutiny, many of these may directly or indirectly encourage doctors to behave in ways that may be detrimental to the patient-doctor relationship.

These unregulated entities are lacunae in our regulatory framework. The doctor-centric regulatory approach needs to be replaced by a comprehensive schema that includes the other players that so heavily influence the professional services provided by the doctor. Regulating the doctor alone is no longer sufficient to protect the central relationship in healthcare.

— Dr. Wong Chiang Yin

ELECTRONIC MEDICAL RECORDS

On-line medical records improve efficiency and reduce wastage, especially when patients visit different healthcare institutions. They also ensure greater patient safety, by allowing access to drug allergy and other vital medical data. However, is such an open platform, holding the patient's intimate medical records, an infringement of the patient's right to privacy?

Commentary

In the drawing, we can see that the National Electronic Health Record, or NEHR, links the family doctor to numerous doctors in hospital. In an emergency, the unconscious patient, arriving at the hospital by ambulance, benefits from data being shared across platforms.

At the same time, we need to consider that such systems come at a price – that of the patient's right to confidentiality and privacy.

Patient confidentiality refers to the obligation of healthcare professionals who have access to patient records to hold that information in confidence. As doctors, we cannot share patient information with third parties without the express consent of the patient. An expectation of confidentiality allows patients to freely share information about themselves, so that the doctor can arrive at an accurate diagnosis and recommend the most appropriate treatment.

Privacy, as distinct from confidentiality, is about the right of the individual to make decisions about how his personal information is to be shared. Patients have the right to control the use of information pertaining to themselves, and should be able to have a say as to when, how, and to whom, information about themselves is disclosed. Regardless of how doctors and administrators feel, there are members of the public who do not wish their health data to be made available through the NEHR. The appropriate response is not to give further assurances of data security but to respect their stand.

— Dr. Wong Tien Hua

Table of Contents

Information Technology and the Doctor

Plaything or Master? We have an exciting toy with multiple functions that promise undreamed-of efficiency. Indeed IT grants us abilities beyond our normal. And yet the time we save may well have to be recycled back into getting to know the toy better!

New Toy, New Problems! Instead of the stacks of dusty cards, we now scroll through screens of unending text. Instead of page-limited charts to monitor trends, we can now compare a boundless series of past results. Do we want to? Do we know how to? And of course, instead of the old filing cabinet, we have the cloud, the power supply, and the broadband access to worry about now!

Whose Toy Is This Anyway? IT engineers design their software to maximise IT performance and to satisfy logic, security, and even accounting principles. Should doctors accept the software according to engineers? Or should engineers design according to doctors' needs?

— Dr. Lee Yik Voon

PROPER AND IMPROPER INFLUENCE

All industries will try to influence their customers, usually in a way acceptable to regulators. It's that way too with the Pharma Industry. But after we become senior doctors (and hence "key opinion leaders") we can by individual choice decline excessively lavish treatment from the industry. And if we become doctors employed by the Pharma Industry, it will be up to us as individuals to find ways that are proper, to make an impact.

Commentary

I was a junior doctor in 1985. In my spare time I tried to write up some data I had collected during my national service days into a paper. It was about the immunosuppressive adverse effects of an antimalarial drug, made by a UK company called Wellcome and used in large quantities by the Singapore Armed Forces. I met with the Singapore-based regional medical director of Wellcome, Dr. Hamish Dyer. Although he knew that my report would mark the end of purchases by the SAF, he looked through my data and made several suggestions to improve the analysis. I asked why he, as an employee of a company whose business would be affected by my work, was so supportive of it. He replied that he was firstly a doctor, and that this professional interaction with another doctor was proper and expected, even though it may eventually be costly to the company. In the two years it took to edit and submit the paper, he never once tried to reshape the way I expressed my findings. The paper was eventually published in the British Medical Journal in 1988.

Dr. Dyer's collegiate approach had a huge and lasting impact on me. My path eventually led me to over thirty years of work in the pharmaceutical industry, and I have tried my best to interact with other doctors in a professional, positive manner.

It is simplistic to think of pharmaceutical companies as prospering thanks to many faceless doctors prescribing their product. A more fruitful perspective is to realise that meaningful interaction is possible by getting to know the doctors employed within the industry. Both parties – without and within – can benefit from the expertise and ideas of the other, leading to potentially better treatment for patients.

— Dr. Lee Pheng Soon

The Drug Rep

The drug rep is someone many doctors will make some time for despite their hectic schedules. She usually looks pleasant and professional and gets to the point quickly in very little time. She gives the doctor quick, organised updates about new drugs and industry trends, and at the end of her visit she will leave behind a variety of small mementoes, all engraved with the name of the drug of the day.

Some say the drug rep is just a pretty face. Some say she is a refreshing distraction from the endless stream of ill patients. Is she an instrument of industry to improperly influence the doctor? In a way the pharmaceutical representative is also giving the doctor she visits a glimpse of the future of medicine. The doctor is the medical expert but the rep is the product expert. The savvy doctor will take the product information and add in his context, his training, and the wider body of evidence to make it useful for his practice.

— Dr. Lee Pheng Soon

MEDICAL ADVERSE EVENTS

About ten percent – the range is five to fifteen from various studies – of hospitalised patients suffer a medical adverse event from treatment. Of these, about half are preventable; one in ten may end in death. Prognostic science in medical practice is weak.

When patients suffer injury or die whilst in medical care, they and their families suffer physical, psychological, and financial loss. This leads to despair and doubt, and erosion of trust in the profession and the healthcare system. Healthcare professionals also suffer despair and doubt, and loss of confidence in their capabilities.

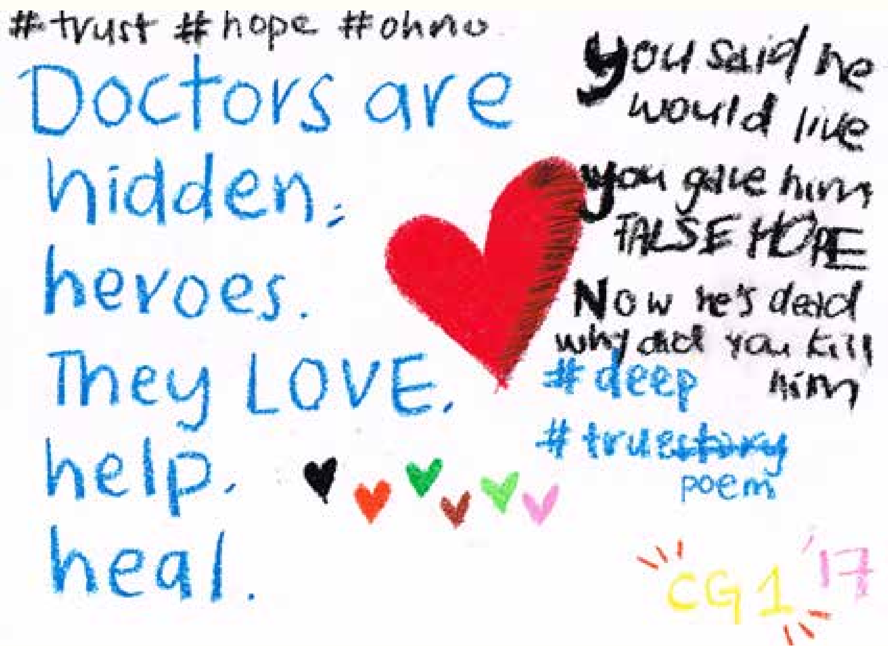
Commentary

When our patients' losses and doubts are not appropriately addressed, they and their families feel disrespected and abandoned. Long-standing and apparently good relationships can be ruptured. The big elephant in the room that needs to be managed is the implicit swirl of emotions.

The entire healthcare team, and not just the doctor, must have a comprehensive and well-understood protocol. The tasks are to institute timely remediation of the medical condition, and to manage the loss and grief of the patient and family. The latter task involves prompt acknowledgement of the adverse event, open disclosure, a clear explanation, and, if appropriate, an apology and early offer of financial settlement.

The therapeutic relationship can be strengthened and trust restored only by upholding the primacy of the patient's welfare with respect, empathy and sincerity.

— A/Prof T. Thirumoorthy



Treading on Eggshells

The climate of practice has changed. In the past couple of years the medical fraternity has faced suits and penalties for cases of missed diagnosis, adverse reactions to treatment, and inadequate informed consent. Even doctors who have practised impeccably may not be spared the wrath of a dissatisfied patient.

The patient's interests remain unquestionably paramount. Nevertheless, many doctors now feel that they are practising on eggshells and are just waiting for the cracks to appear.

This is a lamentable situation for us to have ended up with, both as doctors and as patients.

— Dr. Ong Chooi Peng

OCCUPATIONAL RISKS

Patients fear injury at the hands of their doctors.
Doctors fear catching their patients' illnesses.

Commentary

Doctors are human. We fear catching an infection from our patients. During the early stages of the AIDS* epidemic, instances of hesitation in providing the standard of care surfaced in clinical practice. This happened again with SARS*, and recently during the Ebola* epidemics. The fear is at once repugnant and reasonable.

Doctors are sometimes to blame. We have a professional duty to avail ourselves of protective measures when we care for patients with infectious diseases. This duty wars with the imperative of meeting immediate patient needs. At times we have refused or inadvertently omitted to use recommended precautionary and preventive measures.

It is uncommon, but not unknown, for doctors to catch a blood borne infection by accidental blood spillage or from sharps injuries. When such an event occurs, we have an ethical and legal duty to present ourselves for evaluation, occupational advice, and to comply with appropriate prophylaxis when indicated. Healthcare organisations must create pathways for easy access to medical help, and a non-punitive culture for reporting.

Younger doctors who are in the early stages of clinical experience often harbour fears of contagion and may not know how to share these fears. It is important to establish a special place in the explicit curriculum of medical education where ethical concerns and legal duty of care can be discussed.

— A/Prof T. Thirumoorthy

*The Epidemics
The AIDS epidemic first surfaced in 1981 as a cluster of rare pneumonias in six previously healthy homosexual men.
Severe acute respiratory syndrome, or SARS, is a viral disease. An outbreak in Southern China in 2003 eventually led to secondary outbreaks in Hong Kong, Taiwan, Singapore, and Canada.
The West African Ebola epidemic of 2013-2016 is the most widespread Ebola outbreak in history.

Table of Contents

DOCTOR
There once was a Dr Named Lee
Believed he could save the world did he
But while he was saving a man,
He got cut in the hand
Alas, he had HIV.
CG 13
2019

WORK-LIFE BALANCE

Mummy daddy don't go to work!

These words were uttered over twenty years ago now, but the memories still rankle the emotions.

Choices

Doctors are fortunate and unfortunate. We are fortunate in that our profession allows us the security to choose. We are unfortunate in that our profession is a sometimes a most demanding mistress.

When we step out of our home into the cut and thrust of clinical practice, we leave behind our families. Others care for our children when we are away from them. If we are fortunate, grandparents play surrogate. Oftentimes, it may be a stranger performing a job.

The glory and honour of becoming a doctor rapidly pale beside the pleading cries of our children. Each of us has to make a choice in order to find the balance that works for our situation. Some of us choose the fast lane and some choose the more meandering path. Does one ever have to not choose?

I made my decision years ago. I wanted to serve my community as a doctor. I also wanted to put my family first. I chose general practice, or family medicine in today's parlance. It offered me the opportunity to determine the scope of what I wanted to do, work the hours I wanted to work, and the flexibility to fulfill my responsibilities as a parent.

Nevertheless, the drawing on the next page depicts the tension that the general practitioner continues to face in caring for his patients, and for his family.

— Adj Assoc Prof Tan Tze Lee

The Broken Window

Building up a new practice some forty years ago was challenging. I had to work very long hours and do house calls. Many patients knew my wife and I lived in the flat above the clinic. They would come knocking to seek urgent help after clinic hours.

There was one abusive patient. He had a school-going daughter with asthma. I would often get pager messages from him, and at times, my wife and I had to cut short our night grocery shopping for me to return to the clinic to see his daughter. I do not know why he had to page after clinic hours instead of coming earlier. Often, his daughter just had minor respiratory infections.

One night he paged yet again, but I was engaged on a house call then. When I returned home, my wife told me that one of our window panes was broken. She had heard yelling and banging on our door that night, but had not responded. The yeller had left after throwing a big stone at one of our window panes.

The man returned the next night when the clinic was full of patients. He launched into a tirade about how unethical this doctor was. My wife, who worked the reception after her day job, coolly responded, *So it was you who wanted to come into my house when my husband was not in. We want you to pay for the broken window.* The man froze and beat a hurried retreat amidst laughter from the other patients.

I sealed the cracks with duct tape. We never did get any compensation but we also never feared being harassed again. In time, we saved up enough for the deposit on another apartment and moved away from living just above the clinic.

— A/Prof Cheong Pak Yean

WORK-LIFE BALANCE

Because I have loved life, I shall have no sorrow to die.
— Amelia Burr

Balancing Act

I think that a waiter carrying ten trays and almost dropping one or the other at any one time most aptly symbolises a day in my life. My life is not a neat blueprint. It is a lava lamp, with constant eddies of deep swirling colours.

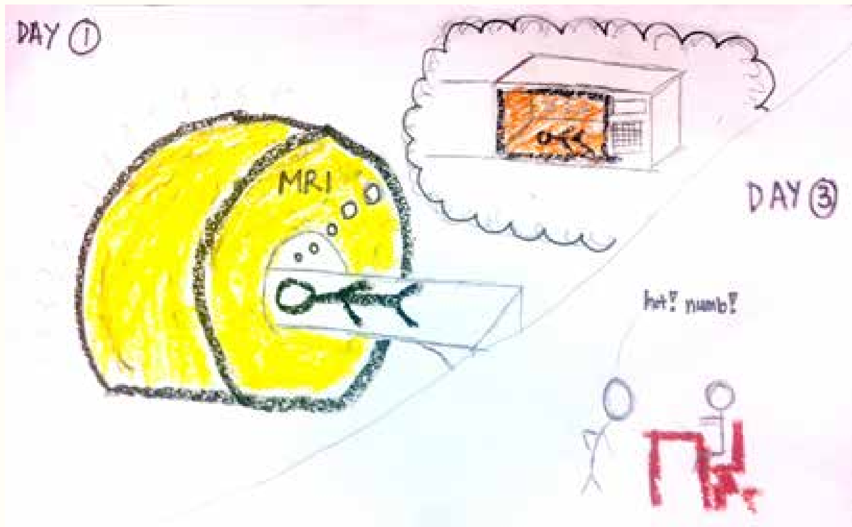
I go to work, which for now is in a polyclinic. I log in and am immediately immersed in my clinical duties. I try to meet the real and imagined expectations of my patients, my bosses, and all others.

Hello there! Who are you? What is your story? What problem can I help you with today? What puzzle can I help you fix?

The drawing shows a patient who had a MRI of his spine three days ago. The scan took forty minutes and he had plenty of time to imagine himself in an oven. Today he comes to the clinic with a hot and numb back. This is a good puzzle for the doctor!

— Dr. Ann Toh

Table of Contents



Lunch break!

There are texts and emails to reply to. Medical students, fellow residents, the grieving mother of a child that I looked after before she died. I remember that I have forgotten to reply someone's email to say thank you. Oops. My residency duty hours – have I logged them? My evaluation forms – have I submitted them? Where have I placed them? My mind carries three to four threads of thoughts at one time, like a highway with cars zooming to and fro.

I have been talking to patients for five hours. I take a stroll to the coffee shop and look at people walking by. I wonder, what is their story? And what is mine? As I sit down to my lunch, after the chill of the clinic, I thaw.

I am busy, I am.

— Dr. Ann Toh

WORK-LIFE BALANCE

As one looks on a face through a window, through life I have looked on God.
Because I have loved life, I shall have no sorrow to die.

— Amelia Burr

More Choices

I need to be on time. I have to-do lists running a like continuous tape at the back of my mind. I need to function – function well! – and deliver, and care, and fulfill, and not generate adverse feedback.

The drawing on the next page shows how we always hope our day does not end. Just before closing time, a patient comes in with a long list of problems to be solved. His list wars with my to-do lists at five in the evening.

My workday ends and I go home. My daughter greets me. I put aside my to-dos and all the incessant buzzing for a while. *How was your day? What was your story today? (How much screen time did you get today?)*

We have dinner together on nights when my husband is not working, chatting about the day, discussing plans. *What did my sister say? What is she doing about it? How are your brother's kids?* A wife is something to be, not do. Not a list of to-dos but to be here, to be with, to be beside.

My daughter nags me to play with her. Sometimes, we do puzzles. Or I sit at her restaurant and we count change. Sometimes we struggle through a book or two so that she earns her television time. I shower her. She combs my hair and I comb hers. Bedtime story. *Mummy can I have another story?*

— Dr. Ann Toh

Me *Time!*

Sometimes I get none, if I fall asleep too soon. Or I catch Netflix or read a book. The last book was about a fire-breathing dragon. My husband enjoys his computer games, or Chinese kung fu novels. Men are still boys at heart.

My day tries to begin at five in the morning. I try to sneak in some work with my coffee, then my regular Grab driver picks me up. I reach the food court at six-twenty and sit there with paperwork, then I head to the clinic.

It's hard for me to grasp work-life balance. To me every hour of my life is bursting with mysterious, interesting, intense, rich flavours. I want to live life.

— Dr. Ann Toh

DOING GOOD AND (NOT) HARM

Beneficence and non-maleficence are two key pillars of medical ethics. In the doing of good we must guard against doing unintended harm.

Commentary

In the drawing, the medical students depict their experience of a bed-side tutorial. Their tutor, the dark figure, lectures a captive entourage of befuddled medical students about hypertension. He is oblivious to the expletives hurled by the agitated man restrained to the bed. Only the little child in the female medical student, all innocence and as yet unacculturated by the medical system, steps forward and exclaims *Oh no!* in empathy. The tutor has unwittingly displayed poor role-modelling of professional values whilst providing medical training.

I confess that as a young doctor, there were times I provided good care without reference to the patient. One such experience is recounted in the vignette. Following intensive care unit protocol, I mindlessly helped to keep the heart of the oldest woman in Singapore beating.

Years later, I had another elderly patient in a nursing home. She was ninety and had been bed-bound and uncommunicative for four years, and she had a *Do Not Resuscitate** directive in her charts. Despite this, she was defibrillated when she collapsed in the home and brought to hospital. In the hospital, her children requested that no radiological or blood tests be done and no intravenous lines set up. She remained in sinus rhythm** post-defibrillation for a few hours and her children were able to bid her farewell.

May we apply our knowledge and expertise with wisdom and empathy.

— A/Prof Cheong Pak Yean

*A Do Not Resuscitate, or DNR, directive is an indication to the medical team to allow natural death in the event of a collapse. The default action that healthcare workers will take in a case of patient collapse is to resuscitate, including using the defibrillator machine.
**Sinus rhythm is the normal heart rhythm.

The Heart That Would Not Stop Beating

It was the late seventies. I was young and energetic and monitoring patients in the intensive care unit. During one of my night watches a patient was rushed in directly from the emergency department after her family had found her unconscious. Tubes were efficiently inserted. Chest compressions. Ventilation. Bloods. Cardioversion. We were in control. The mechanical thumper was brought in. This lady was extra small, but we got the thumper working on her after a while. Just as we thought we had stabilised her, her rhythm became chaotic again. Just as we wanted to stop resuscitation, it returned to sinus. These cycles went on for over two hours before her heart mercifully stopped beating.

Two days later, I happened to read her obituary in the newspaper. There was a short essay attached, entitled *The oldest person in Singapore died peacefully in hospital*. She had been a hundred years old. Her last hours had been spent amongst strangers fixated on her heart rhythm to the point of absurdity. I would not have used the word *peaceful*.

— A/Prof Cheong Pak Yean

PHYSICIAN, HEAL THYSELF

We spend a lot of time telling patients what to do. Is our advice effective?

Sometimes, in order for our advice to be effective, we physicians need to do what is needful, and get our own house in order, first.

Commentary

It is a worthy exercise to consider how we give our advice.

First and foremost, consider our demeanour, our physical appearance, and our message. These need to be aligned to what we are seeking to achieve for our patient. In this case, it is helping the patient to lose weight. The doctor needs to be an example for the patient.

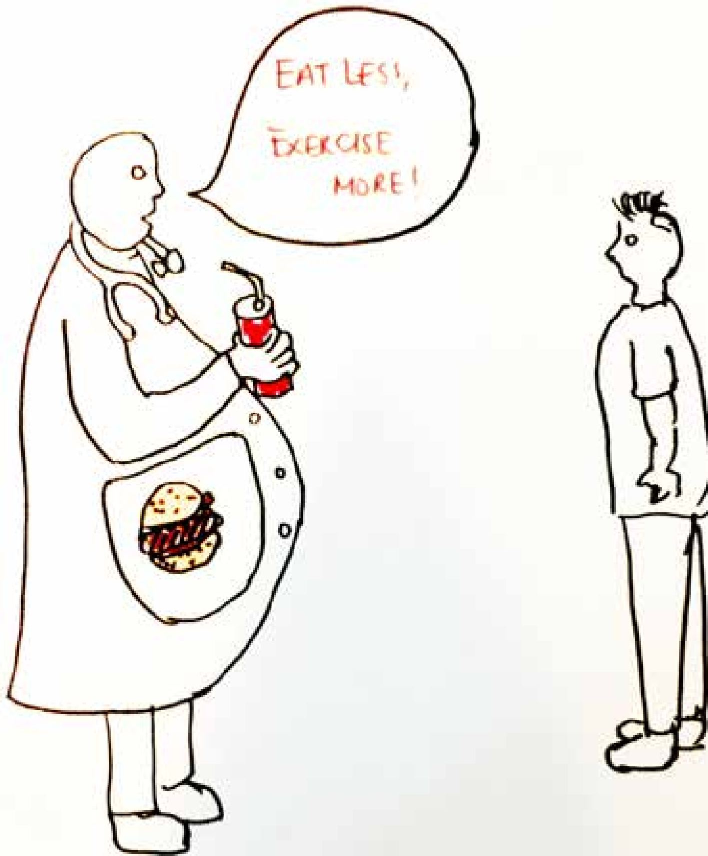
The fat doctor is drinking a sweetened beverage. He has some food (a burger!) tucked into the pocket of his white coat. The doctor does not appear to have fixed his own problems. How is he going to be able to give advice that will be followed? A doctor may be all ready to treat others, yet he may not have taken the first step to efficacy.

One more point is to be noted for reflection. Doctors say, *eat less, exercise more.* This is the counsellor's script. It has been commented that a coach's script may be more effective. A coach says, *have you thought about how you could lose weight?* This gives the control back to the patient.

The doctor in the drawing may wish to ask himself the coach's question.

— A/Prof Goh Lee Gan

Table of Contents



One-Act Play

Doctor: To succeed in losing weight, you will have to eat less and exercise more.

Patient: [Verbally] Yes, doctor. [Thinking] This must be a joke! I am not going to lose much weight under his care. He is a failure himself! Look at him – eat less, exercise more??

— A/Prof Goh Lee Gan

LIFE IS A JOURNEY

Life is a journey, not a destination.

Many of us come to this realisation over time.

Commentary

There is a parallel between the driving licence and the doctor's licence to practice. In order to drive safely, we learn to do it right and then do it rightly. The skills learnt are used long after we pass the driving test and obtain our licence. In time, with exposure to driving conditions that exercise those skills, we become better drivers. So, although getting a driver's licence is an objective, what is more important is that it marks the beginning of a journey through life as a safe driver.

Medical practice is an exact parallel to driving a car. Our licence to practice is the official endorsement that we have shown the capacity to practice safely. In a nutshell, we have learnt how to take a history of the patient's symptoms, examine for physical signs to support our differential diagnoses, and investigate where necessary, in order to arrive at an appropriate conclusion. This gives us the basis to institute a certain course of treatment for the patient.

The patients that we see, and these processes that we navigate, together create our professional journey as medical practitioners. The repeated cycles of doing, learning, relearning, and improving make us better doctors. The degrees hanging on the wall are just testimony to the steps to proficiency. Indeed, doctoring is a journey and not a destination.

— A/Prof Goh Lee Gan

Table of Contents

*Ars Longa, Vita Brevis**

This drawing is captioned *Life is a journey, not a destination.*

Two ideas are drawn here.

On the right side, in the foreground, is a framed photograph of a graduate posing with his proud parents. The young graduate doctor has reached his destination.

On the left, in the background, the young doctors are examining a patient. They have left their initial destination behind and have now embarked on their life-long journey.

— A/Prof Goh Lee Gan

*Latin phrase meaning, "Art is long, life is short".

ART AND SCIENCE

Care more particularly for the individual patient than for the special features of the disease.

— Sir William Osler

Commentary

The science of medicine is, we like to think, research-based, algorithm-driven, logical, and reductionistic, drawing from the wider body of evidence to reach our patient's diagnosis and management. The art, on the other hand, has always been somewhat nebulous. We think of a colleague with years of experience and an inexplicable instinct for the correct conclusion. We think of some older physician who can calm his distressed patient with a word.

Perhaps the two are the sides of the same coin.

The science draws from the world to the patient. The art starts with the patient to the world.

The calligraphy on the next page is an old saying that is often seen in doctors' rooms. This set was written by a medical student attached to my clinic. The words describe a good practitioner with both heart and skill. With these four words, I think the ancients have captured the art-science construct most elegantly.

— A/Prof Cheong Pak Yean

Calligraphy by Phoong Zhia Ying

Gentle Epiphanies

I have a pair of Norman Rockwell reproductions on the wall in my clinic. To me, *The Doctor and the Doll* (1929) represents the art of medicine, with the doctor relating to a frightened little girl by examining her doll. *Before the Shot* (1958) depicts the science, with a doctor in his white coat preparing to inject the exposed buttock of a young boy. These reproductions have inspired reflections about the mechanics of practice with generations of medical students.

One student was pleasantly surprised that a clay model given by her grandmother when she started medical school, was based on the first painting. A gift to a beloved grandchild embodies the elder's hopes for that child to gain art and wisdom as she starts her life's studies.

— A/Prof Cheong Pak Yean

Epilogue

This book is a collection of pictorial observations of the illness experience by medical students, and of reflective prose of the same by veteran family physicians. The first edition was well received by the medical fraternity who could identify with the accounts therein. Some patients were also able to relate to the stories. One patient asked for additional copies of the book. When probed, she revealed that she wanted to use the vignette in *Still Family* about same-sex marriage to break the news of her daughter's upcoming nuptial celebrations.

The Covid-19 pandemic and consequent global disruption have increased our awareness of our common experience. In a way, the affliction of the "heart" in the Zika outbreak of 2016 shared in *The Plague of Epidemics* was an ominous herald of the pandemic that currently besets us. The material in the book provides a useful substrate for enriching the experience of doctors and students.

This book serves an additional mission, which is to train family physicians to venture beyond the framework of evidence-based medicine into the realm of narrative-based medicine. Narrative-based medicine, with a focus on the experiences of the various illness participants, helps us to see health and disease in the context of the wider human condition. We hope *Being Human* is a small step in this direction.

Cheong Pak Yean & Ong Chooi Peng
October 2021

About the Drawings

The drawings in this book were produced by successive cohorts of medical students from 2012 to 2017. This was done in a workshop to round up the patient encounter experiences, which was conducted by A/Prof Cheong Pak Yean towards the end of their Family Medicine posting in the third year at Yong Loo Lin School of Medicine, National University of Singapore.

These drawings represent the perceptions of beginning practitioners, looking at healthcare custom and interactions with youthful eyes.

For each drawing, the year the drawings were produced and the clinical group reference are indicated. For some drawings, we are able to identify the group or the year, but not both, and for some, we deeply regret that we are able to identify neither.

Chapter 1

1.1 2017 CG15*; 1.2 CG29; 1.3 2017 CG40; 1.4; 1.5 2013 CG2; 1.6 2013 CG15; 1.7 2012 CG4; 1.8; 1.9 CG2

Chapter 2

2.1 2014 CG37; 2.2 2017 CG18; 2.3 2013 CG13; 2.4 2013 CG25; 2.5 2014 CG41; 2.6 CG16; 2.7 CG28; 2.8; 2.9 2013 CG01; 2.10; 2.11 2013 CG10; 2.12; 2.13 2012 CG1; 2.14 2012 CG15; 2.15 2016; 2.16 2012 CG3

Chapter 3

3.1; 3.2 2012; 3.3 2013 CG5; 3.4 2013 CG11; 3.5 2013 CG06; 3.6 CG5; 3.7 2017 CG43; 3.8 2012 CG7; 3.9 2012 CG38; 3.10; 3.11 CG24; 3.12; 3.13; 3.14 2012 CG14; 3.15 CG42; 3.16 2012 CG39; 3.17 2012 CG12; 3.18 2014

Chapter 4

4.1 2013 CG19; 4.2 2014; 4.3 2013 CG12; 4.4 2012 CG37; 4.5 2012 CG36; 4.6 2012; 4.7 2013 CG1; 4.8 2013 CG18; 4.9 2013 CG29; 4.10 CG34; 4.11 2013 CG23; 4.12 CG7; 4.13 2014; 4.14 2012 CG34

Chapter 5

5.1; 5.2 2013 CG28; 5.3 2017; 5.4; 5.5 2013 CG38b; 5.6 2017 CG1; 5.7 2018 CG13; 5.8; 5.9; 5.10 2012 CG33; 5.11 2017 CG38; 5.12; 5.13 CG13; 5.14 2018 Phoong ZY

*1.1 2017 CG15 means that the drawing in Chapter 1.1 was drawn in 2017 by Clinical Group 15.

About the Editors and Contributors

The following doctors have dipped deeply into their troves and shared liberally. As the focus of this book is on the human experience, details of post-graduate qualifications and institutional affiliations have been omitted. The year of graduation is included to provide a context to the reflections shared. The numbers refer to the chapters contributed by the individual doctors. Unless otherwise stated, they are all family physicians. The information was accurate at time of printing the first edition in 2019.

Editors

Cheong Pak Yean (MBBS 1974) is a family and internal medicine physician who is also a psychotherapist in private practice. He teaches undergraduates and has an interest in medical humanism and communication, and is a past president of the College and the Singapore Medical Association. (1.4, 1.5, 1.6, 1.7, 1.8, 1.9, 2.6, 2.15, 3.6, 4.1, 5.8, 5.11, 5.14)

Ong Chooi Peng (MBBS 1988) practises in a polyclinic and also in a community hospital. She counts it her blessing to have been part of Family Medicine in Singapore through a time of formation and growth. (1.4, 2.6, 4.1, 5.2, 5.6)

Contributors

Ang Lai Lai (MBBS 1984) practises in a polyclinic and is part of the clinical faculty for undergraduate and postgraduate Family Medicine training with NUS. She is also accredited as a medical mediator. (3.13, 3.14, 3.15)

Angela Tan Qiuli (MBBS 2007) works with geriatric and palliative patients in the community. She is certified in sexual medicine and is also an intimacy coach in private practice. She teaches medical students and has a special interest in human dynamics. (3.7, 3.8, 3.9)

Ann Toh (MBBS 2010) is a Family Medicine resident who enjoys the privilege of caring for patients in the context of their real lives from cradle to grave, and feels that she is currently passionately pursuing the heart of medicine. (3.3, 3.4, 3.5, 5.9, 5.10)

Chang Tou Liang (MBBS 1990) is in private practice. He is a husband, father, piano fancier, cat collector, and is also sometimes remembered as the most prolific music reviewer of *The Straits Times* ever. (2.16)

Chong Phui-Nah (MBBS 1991) is a family physician, clinician administrator, and clinical teacher. She is based in the polyclinics and is interested in primary care transformation, behavioural economics, and healthcare innovation. (2.4)

Choong Shoon Thai (MBBS 1997) works in a polyclinic and also runs a weekly Dungeons & Dragons game. (2.10)

D Gowri (MBBS 1992) is a family physician with additional duties in care integration. In her spare time, she enjoys listening to others, having deep conversations, learning, and occasionally having some time alone. (3.17)

Darren Seah (MBBS 2001) is a family physician with an interest in cardiovascular medicine and endocrinology. He is also the programme director of a Family Medicine residency. (1.2)

Goh Lee Gan (MBBS 1971) is a past president of the College, the Singapore Medical Association, as well as the Asia Pacific chapter of the World Association of Family Doctors. He started the academic Family Medicine programme in NUS in 1987 and also the Master of Medicine training programmes. He considers himself the midwife of Family Medicine in Singapore although many of us think of him as the father! (2.6, 5.12, 5.13)

Goh Wei Leong (MBBS 1985) is in private practice. He co-founded a charity to serve migrant workers in 2006 and was named the Singaporean of the Year in 2017 by *The Straits Times*. (2.11, 2.12)

Grace Chiang (MBBS 2012) is a family physician with a background in public health, who is currently practising in a community hospital. Her research and clinical interests include population health, ageing in place, and frailty. (4.2, 4.3)

Grace Lum (MBBS 2013) works with home-bound patients and ambulatory patients in a community hospital. She is also a wife and mummy to a toddler and a handsome brown dog. (4.4, 4.5)

Irwin Chung (MBBS 1999) practises in a polyclinic. He is interested in professional education, end-of-life care, and clinical practice improvement. (1.1)

Jean-Jasmin Lee (MBBS 2000) is a family physician with accreditation in sexual medicine. She has a special interest in paediatric and women's health. (3.7, 3.12)

Julian Lim (MBBS 1988) is in private practice. He actively teaches in the College graduate diploma and fellowship programmes and is the long-suffering and longest-serving past director of the College Master of Medicine programme. (1.9)

Lee Kheng Hock (MBBS 1987) was a general practitioner for ten years before he set up the first Family Medicine department in a hospital in Singapore. He currently works in a community hospital and is involved in undergraduate teaching, care integration, community-based medical education, and health services research. He is a past president of the College and the current Chapter of Family Medicine Physicians chair at the Academy of Medicine. (2.5)

Lee Pheng Soon (MBBS 1982) is a family physician in private practice who is also a pharmaceutical physician employed by the industry. He is a past president of the Singapore Medical Association and comes from a long family tradition of GPs spanning four generations. (5.5)

Lee Yik Voon (MBBS 1987) practises in MacPherson and is a member of the National General Practitioner Advisory council. He is a pet lover, proud owner of a dog, and regular feeder of the neighbourhood cats. He plays online war games and feels that playing Pokemon Go is a good form of exercise. He is the current president of the Singapore Medical Association. (5.4)

Lily Aw (MBBS 1980) is the clinical lead for a Primary Care Network. For the past thirty years, she has driven across town from home to her clinic to attend to her patients. In the past year, however, her journey has included a stop to play with her grand-daughter who has totally and

irrevocably captured her heart! (2.13, 2.14)
Lim Chee Kong (MBBS 1996) is a senior consultant family physician in a polyclinic. (2.3)

Lim Fong Seng (MBBS 1990) is the past head of the Division of Family Medicine at NUS. He enjoys reading, watching movies, and soccer, and is an avid fan of the biggest British football club in the world. (2.1)

Linus Chua (MBBS 2008) is practising in a community hospital, with a special interest in dementia care. He is involved in community and humanitarian projects locally and overseas. (1.6)

Loh Cheng (MBBS 2001) is in public service and in the past has been involved in rehabilitation and elderly care training in Yunnan, China. (2.11, 2.12)

Low Lian Leng (MBBS 2006) is a family physician in a tertiary hospital. He is passionate about population health, ageing, and integrating health and social care. (4.6)

Family Medicine runs in Luke Low's (MBBS 2005) family blood, seeing that it has infected both him and his brother. It has given him a passion for his patients and inspired him to contribute to his fraternity. (4.7, 4.8)

Marie Stella P. Cruz (MBBS 1989) provides care to patients in nursing homes. She is interested in care for the older adult, the institutionalised patient, and the home-bound patient, as well as end-of-life care. She also teaches undergraduates and post-graduates and is involved in assessment. (4.9, 4.10, 4.11)

Matthew Ng (MBBS 1988) is a family physician in a tertiary hospital who also teaches undergraduates. He is a past editor of the Singapore Family Physician and continues to be the long-serving chief examiner of the GDFM examination. (3.18)

Ng Lee Beng (MBBS 1980) finds her energies and passions shared between patient care, training the next generation of family physicians, advocating advance care planning, grandparenting, and community gardening. She is mindful of the need to use her days well for that which will be of the most lasting value. (1.3)

Ruth Lim (MBBS 1995) practises in a polyclinic and has several appointments in education including being the Clinical Assistant Dean at Duke-NUS Medical School. She also chairs of the Family Medicine Examination Committee. (3.2, 3.3)

Suraj Kumar (MBBS 1984) is in private practice and is also the honorary secretary of the College of Family Physicians. He succeeded Julian and is the current director of the College Master of Medicine programme. (2.8)

Tan Boon Yeow (MBBS 1992) practises in a community hospital and has a particular interest in geriatric care, and he is actively involved in undergraduate and postgraduate teaching. His greatest joy is spending time with family and friends and with God, and he strives to find time to do it all. (4.4, 4.5)

Tan See Leng (MBBS 1988) spent some time in general practice following a stint in the public sector. Although he is now a full-time administrator, he remains deeply interested in the primary care delivery ecosystem. (5.2)

Table of Contents

Tan Su-Ming (MBBS 1990) has been a general practitioner in solo practice in the heartlands for twenty-three years. She believes that if we knew everyone's back story, we would be kind to everyone. (2.7, 3.1, 3.16)

Tan Tze Lee (MBBS 1987) is the president of the College of Family Physicians, Singapore. He is a principal in his private practice where he has taught successive cohorts of medical students. He is also the president of the COPD Association of Singapore. (5.8)

Tan Yew Seng (MBBS 1990) is qualified in family medicine, palliative medicine, psychotherapy, and chaplaincy. He practises privately and also volunteers with the Indonesian Children's Hospice and the Nomads Clinic in Nepal. (4.12, 4.13, 4.14, 4.15)

Tay Wei Yi (MBBS 2006) practises in a tertiary hospital and also actively teaches postgraduates. She is passionate about nurturing future generations in the breadth of Family Medicine. (4.6)

T. Thirumoorthy (MBBS 1972) is the Group Chief Medical Officer with a private healthcare group who also teaches at Duke-NUS Medical School. He is a dermatologist and the founder director of the SMA Centre of Ethics and Professionalism. (3.10, 3.11, 5.6, 5.7)

Tung Yew Cheong (MBBS 1996) practises in a polyclinic and is also involved in overseeing quality and safety matters. (2.9)

Vincent Chan (MBBS 2004) practises in the heartlands. He loves the people aspect of his job, and hopes he is serving the community well as a general practitioner. (2.2)

Wong Chiang Yin (MBBS 1994) is a public health specialist who was previously chief operating officer of two major public hospitals. He is a former president of the Singapore Medical Association and is part of the current elected council of the SMA and the Academy of Medicine. (5.3)

Wong Tien Hua (MBBS 1993) is in private practice and is a past president of the Singapore Medical Association. His interests are in primary care, medical ethics, and patient-doctor communication. (5.1, 5.4)

Kirpal Singh (BA Hons 1973) is a writer and academic who enjoys provocations and good friendships.

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Index

A
Abortion 2.13
Addiction 2.8
Adherence 2.3, 2.4
Adverse effects 5.6
Ageing 3.1
Alternative medicine 2.2
Anorexia nervosa 2.9
Art of medicine 5.14

B
Beneficence 5.11

C
Child abuse 3.5
Children 2.14, 3.4, 3.5
Cholesterol 1.4, 1.5
Columbo technique 1.7
Colorectal cancer 1.1, 2.2
Common conditions 2.1
Communication 1.4, 4.1
Compassion 1.3
Confidentiality 5.4
Conflicting interests 5.2
Cough 2.8

D
Deformities 4.1
Dengue 2.1
Diabetes 1.1, 1.5, 2.3, 2.4, 2.11, 2.12, 3.12, 4.6
Diarrhoea 2.16
Disability 4.4, 4.5
Death 4.12, 4.15, 5.11
Drug rep 5.5

E
Electronic medical records 5.4
Emergencies 2.10
Empathy 1.2
End of life 4.12, 4.13, 4.14, 4.15
Epidemic 2.15

F
Family violence 3.2, 3.3
Fatigue 1.8
Fees 5.1
Fostering 3.4
Fragmentated care 2.5, 2.6

G
Gender issues 3.16, 3.17, 3.18
Gout 1.9
Graves disease 2.6

H
Headache 1.8
Health education 1.4, 2.7, 5.12
Heart disease 1.9
Hope 1.3
Hypertension 1.2

I
Ill-defined symptoms 1.2
Information technology 5.4
Injuries 2.10, 2.11
Internet 1.5
Isolation 4.2

J
Journey 5.13

K
Klinefelter syndrome 1.6

L
Leukemia 1.5
Listening 1.2
Loneliness 4.3

M
Masquerade 1.6
Migrant workers 2.11, 2.12, 2.13, 2.14
Munchausen syndrome 1.7
Munchausen by proxy 1.8

N
Non-maleficence 5.11
Nursing home 4.8, 4.9, 4.10, 4.11

O
Occupational risks 5.7
Orphan 3.4

P
Paraplegia 4.4
Parkinson's disease 1.3
Pharmaceutical industry 5.5
Pregnancy 2.13, 3.13, 3.14, 3.15
Privacy 5.4

R
Regulatory matters 5.3
Rehabilitation 3.8, 4.4, 4.5, 4.6, 4.7, 4.8
Resuscitation 5.11

S
Same-sex 3.18
SARS 2.15
Sex 3.7, 3.8, 3.9, 3.10
Sexual boundaries 3.6
Sexually transmitted infections 3.10, 3.11, 3.12
Skin diseases 2.1
Smoking cessation 2.7
Social factors 2.4, 4.2, 4.3
Spiritual care 1.9, 4.14
Stroke 1.4, 4.5, 4.10

T
Teenagers 3.13, 3.14, 3.15, 3.17
Transitional care 4.6

U
Upper respiratory infection 2.1

W
Work-life balance 5.8, 5.9, 5.10

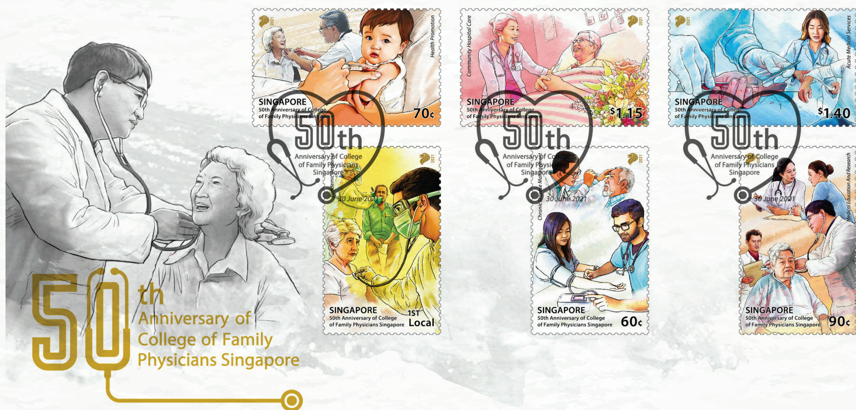
Z
Zika 2.15

Last Words

" This is our private fight so you stop butting in ! "

" Your husband needs complete rest. I want YOU to take these tablets three times a day. "

Dr. Koh Eng Kheng (MBBS 1955) was a founding member of the College of Family Physicians Singapore who served as President from 1989 to 1991. He was also a keen observer and witty artist and many of us can totally relate to his two cartoons here. We thank his son Dr. Kevin Koh (MBBS 1981) for sharing them.



Being Human: Stories from Family Medicine combines the observations of medical practice by young medical students with the reflections of seasoned practitioners. The result is a work that spans the breadth of Family Medicine and gives the reader an honest glimpse into the heart of the family doctor.

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