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.

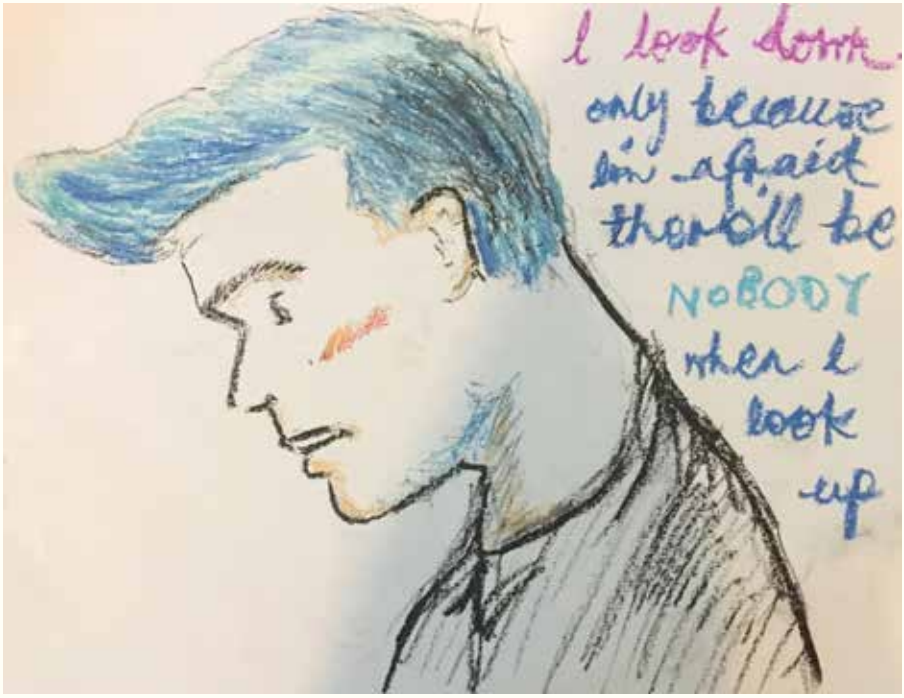
As doctors, we wield our pen and scalpel so confidently, but we are often impotent when the patient is weighed down by the burden of his illness. Perhaps at such times we can learn to put aside our prowess and simply be the patient's encourager along the way to recovery and healing, or the fellow traveller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

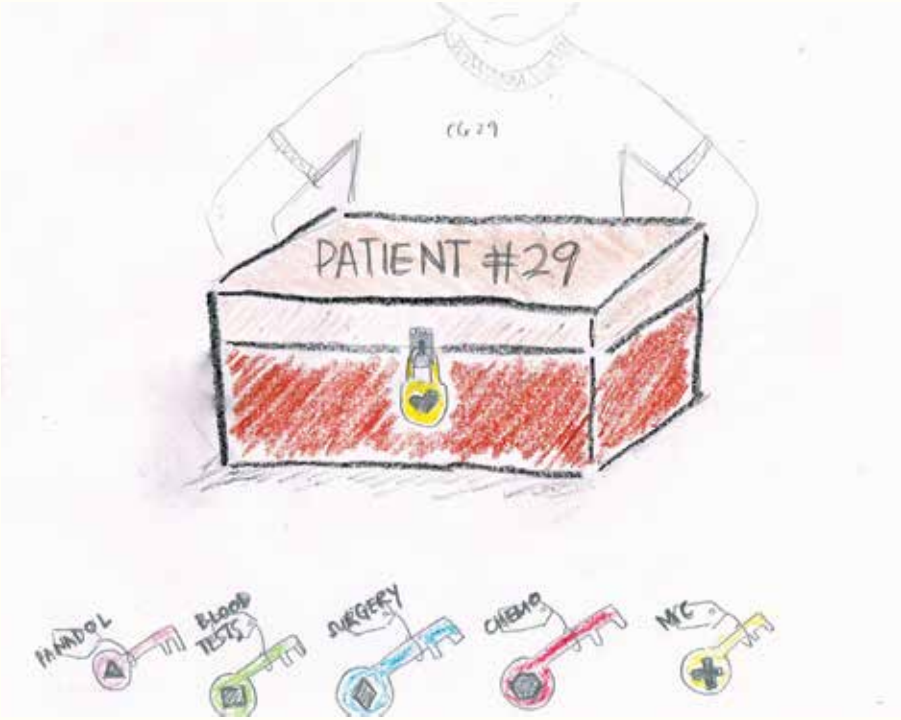
The drawing depicts a nameless patient who is identified only by a number. He carries a box with a lock. The box holds the patient's true problem, packed up in layers of his ideas, concerns, and expectations. The doctor needs to choose the correct key, or keys, with which to unlock the box and to understand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

Table of Contents

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

Table of Contents

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!

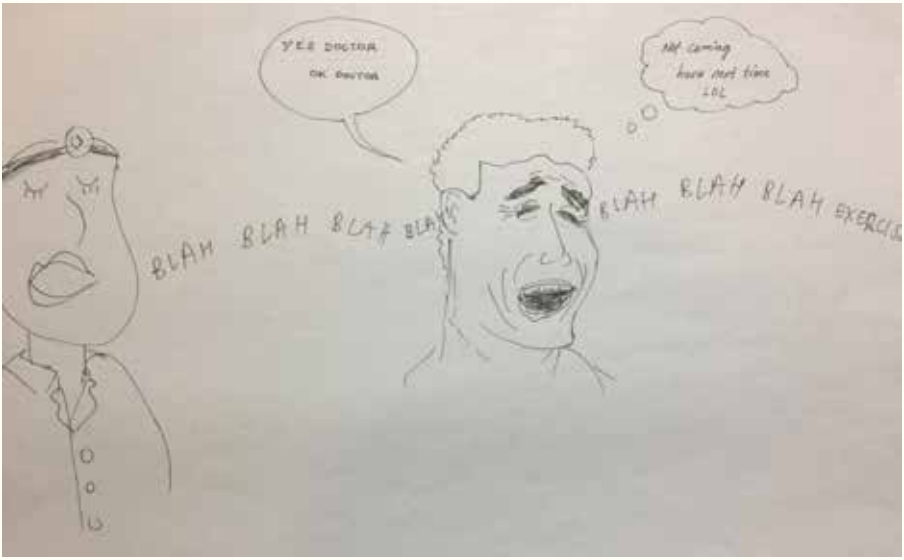
What we talk about has changed. *If you don't watch your sugar I will have to start insulin,* we said. *Here's what we can do,* we say instead, now. *What are your goals of care? What values matter to you? Do you want antibiotics? Do you want tubes? How are you doing in school? What does your partner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

Table of Contents



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

Table of Contents

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

Table of Contents

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

Table of Contents

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.

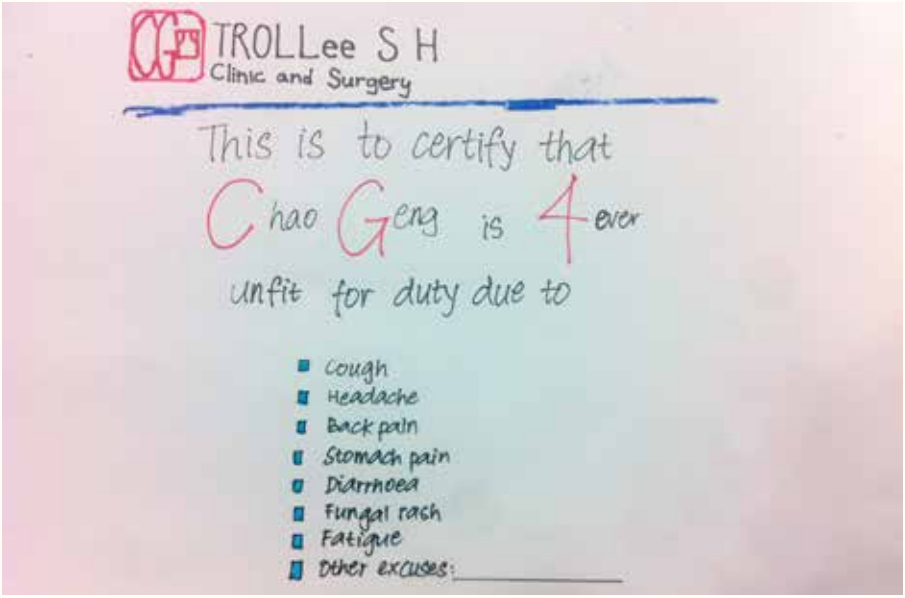
The situation becomes distressing to the doctor when such a patient presents with a history that may portend serious illnesses, which is not readily excluded by careful questioning or examination. The patient described in the vignette presented with an acute onset of unsteady gait and giddiness. The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

Table of Contents

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

Table of Contents