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.

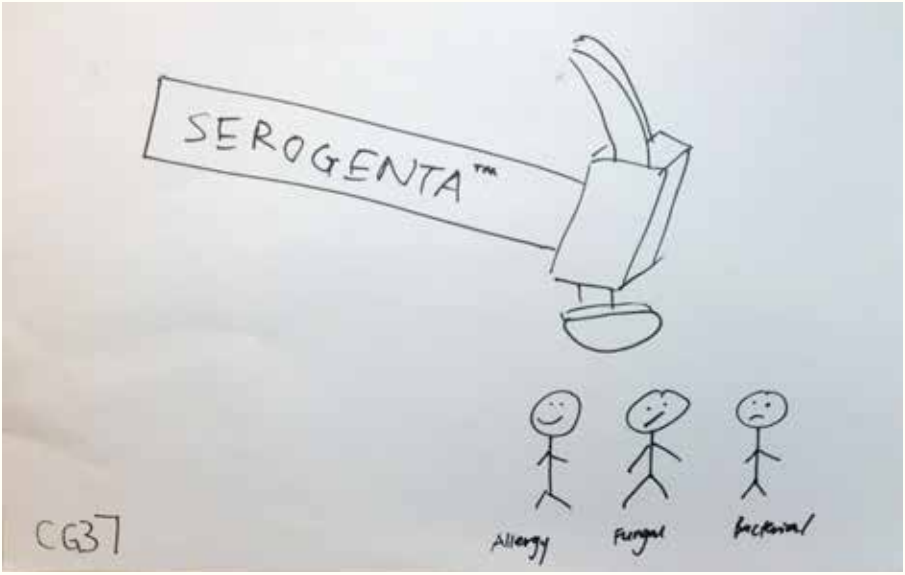
URTI is a syndromic diagnosis. The dassic symptoms and signs present together to suggest the diagnosis, but there is no test that confirms it. It is important to remember that when symptoms and signs are not localised to a site, the diagnosis may not be URTI, even though it is the commonest condition 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

Table of Contents



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

Table of Contents

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 indude 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

Table of Contents

Table of Contents

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.

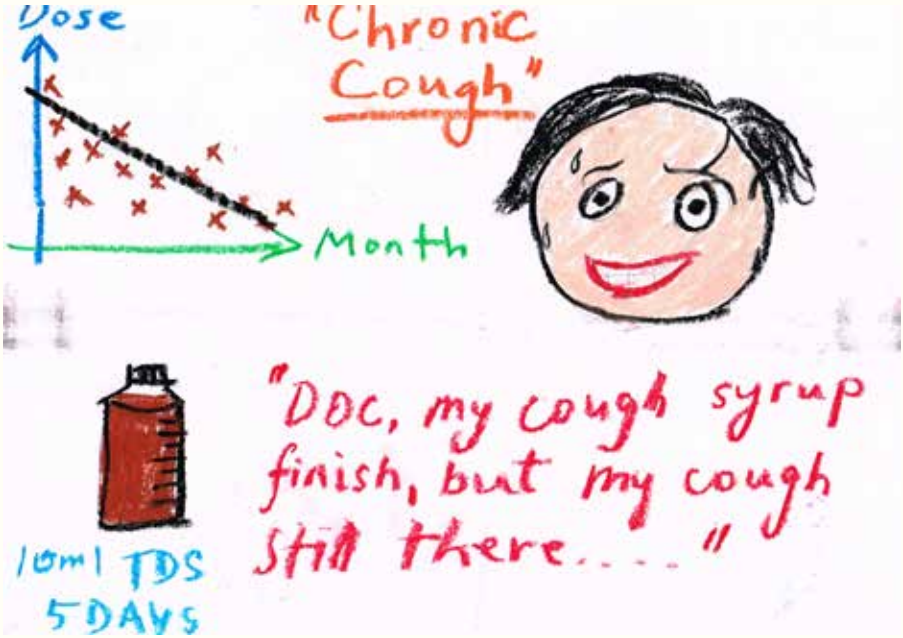
In the drawing we see a young patient with what appears to be a forced smile. Is this someone with something to hide? The chart in the background illustrates the pattern of his cough mixture consumption. Is the patient here for more of the same today?

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.

Table of Contents



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

Table of Contents

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 deanness 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

Table of Contents

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.

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.

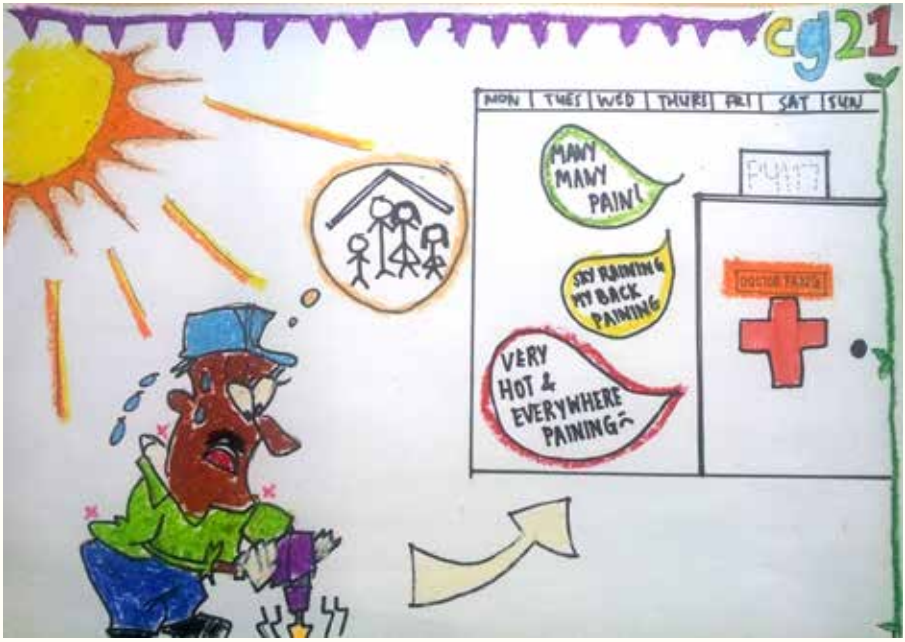
The man expresses his pain ungrammatically as *many, many pain* and in present continuous tense, *sky raining, my back paining … very hot and everywhere paining*. It is important to listen actively for the meaning behind the worker's expression, in order to understand them in their cultural context.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

Table of Contents

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.

Table of Contents

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.

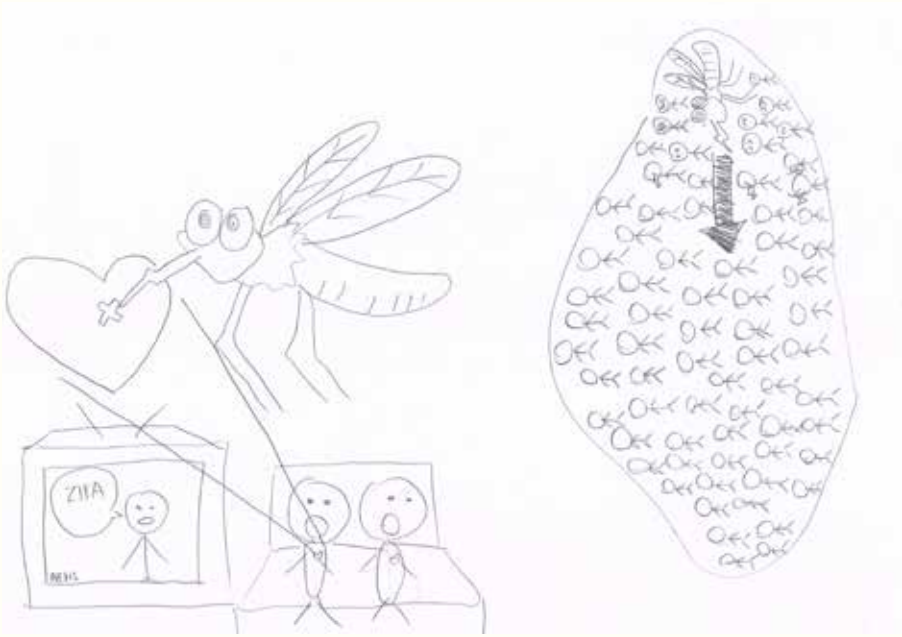
The limited Zika outbreak in 2016 was quite unlike the SARS epidemic in 2003. SARS is transmitted by a virus that spreads through body fluids, chiefly respiratory droplets. It ravaged Singapore for five months in 2003, infected two hundred and thirty-eight people and killed thirty-three. Initially confined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

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