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Chapter Four

Being Human

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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

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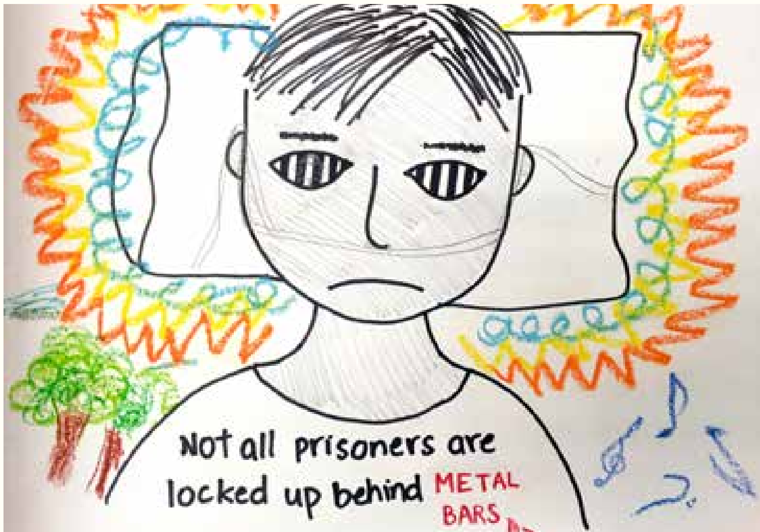

In the Midst of Plenty

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

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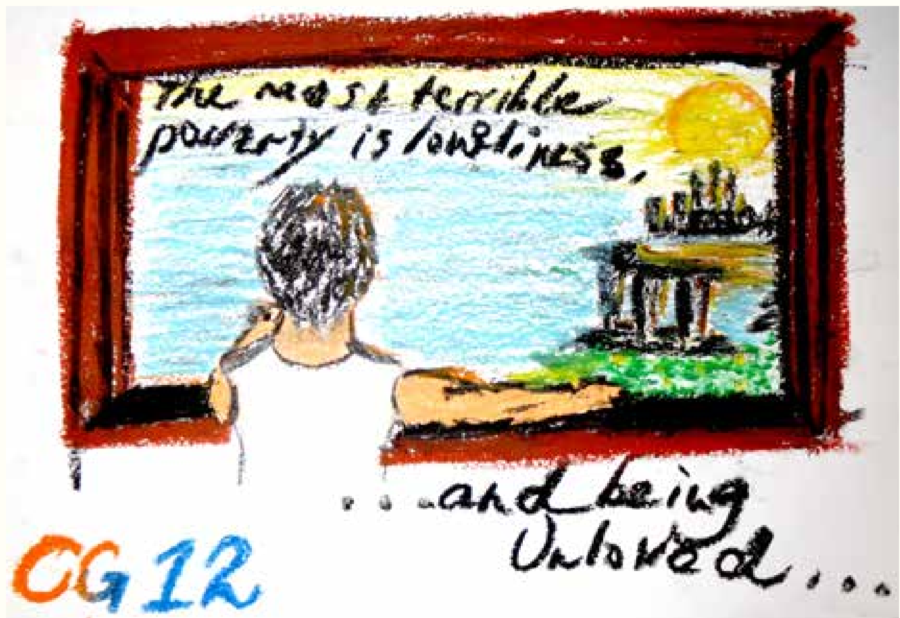

Plenty Poor

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

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

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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

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

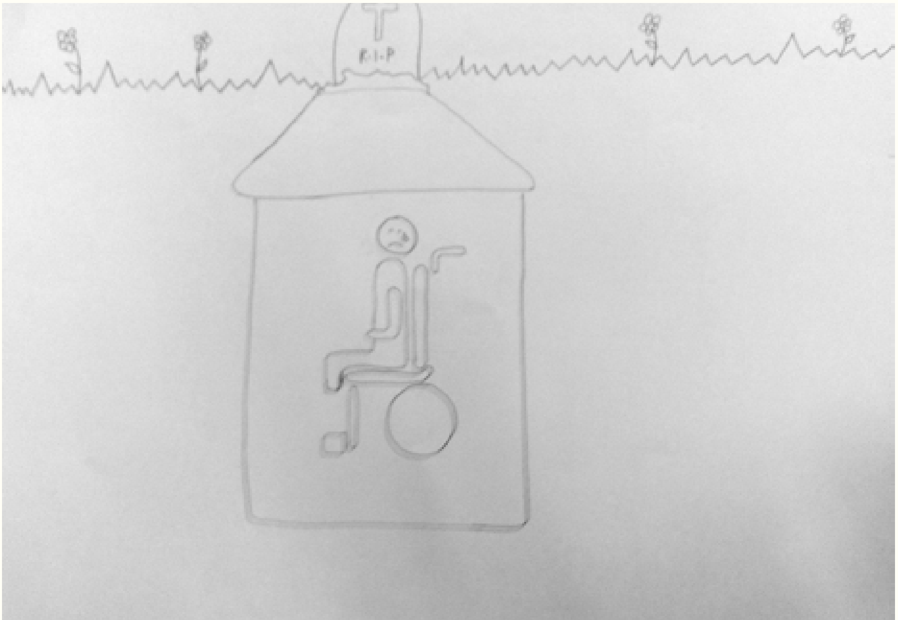
Transitional care is especially vital to aid our patients with multiple morbidities and complex biopsychosocial needs as they move from an acute care setting back to their community.

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



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

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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.

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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

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.

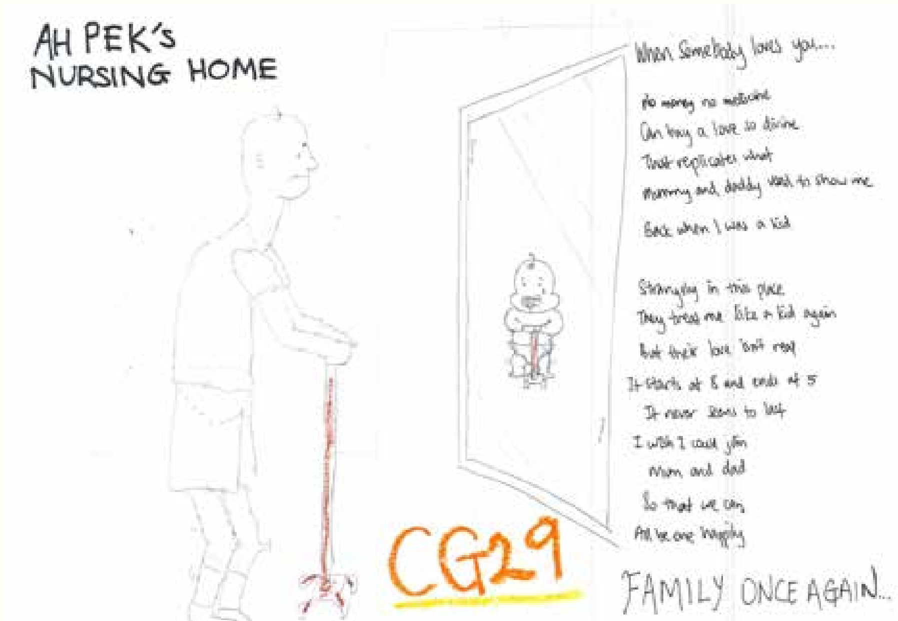
Commentary

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



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.

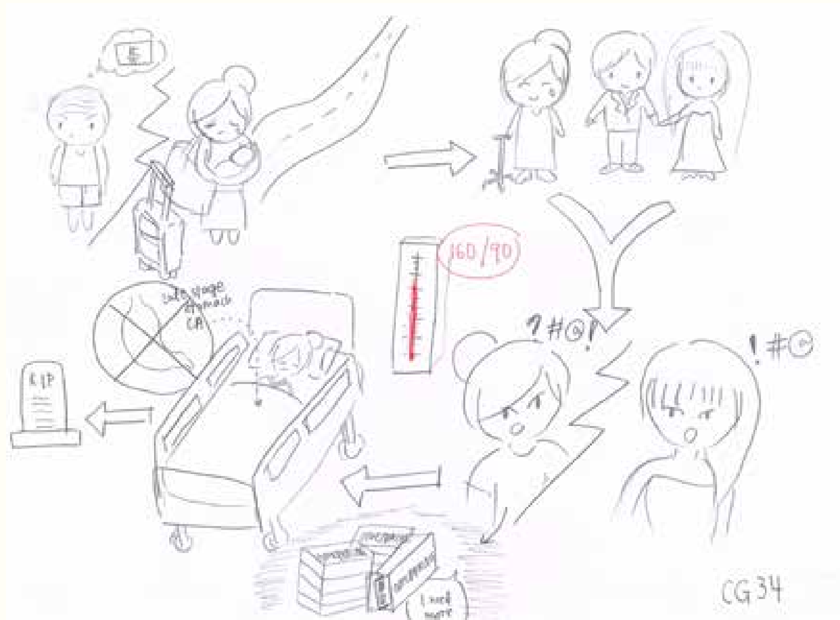
Sorrow

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



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.

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

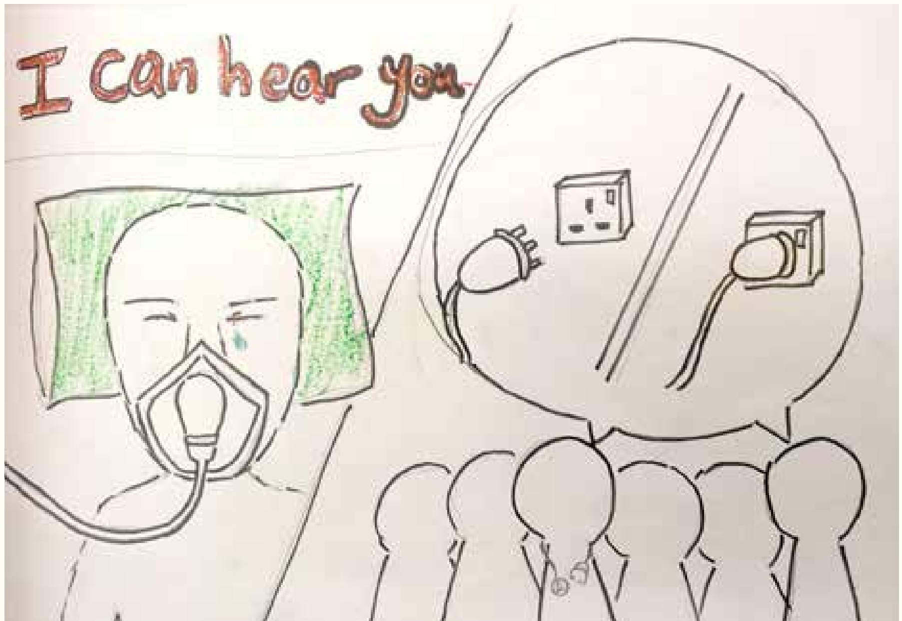
The drawing is a composite of two scenes. To the right a group of doctors is huddled in discussion. They are faceless and have disproportionately huge heads with amorphous bodies. Emanating from two of the heads is a speech bubble that depicts the content of their discussion, i.e. pulling the plug. On 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


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

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

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

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