THE DOCTOR AND THE PATIENT
CHAPTER 1.4

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

This drawing was produced by third year medical students at Yong Loo Lin School of Medicine, National University of Singapore between 2012 to 2017.

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

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THE DOCTOR AND THE PATIENT
CHAPTER 1.9

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 which may be spiritual and even paranormal in nature. The compleat family physician attends.

- Dr. Julian Lim

This drawing was produced by third year medical students at Yong Loo Lin School of Medicine, National University of Singapore between 2012 to 2017, by CG2

(continued on the next page)

(continued from Page 22: Beyond Comprehensive Care)

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

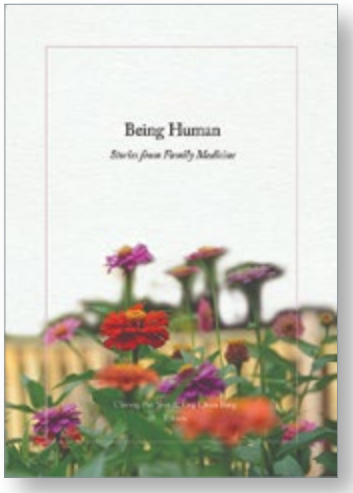
Further Reading

Chapter

1.9 Julian Lim. "Death in the Clinic." *SMA News* Mar 3303; 9-10

Cheong PY. "Chasing Dragons & Exorcising Demons." *SMA News* Nov 2015; 20-21

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



About the Editors and Contributors

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

Editors

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

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

Contributors

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

Contact Cynthia (+65 9668 1004) to purchase the 168-page book at $16 per copy