Chapter Five

In Practice

THE BUSINESS OF MEDICINE

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

Commentary

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

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

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

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

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

— Dr. Wong Tien Hua

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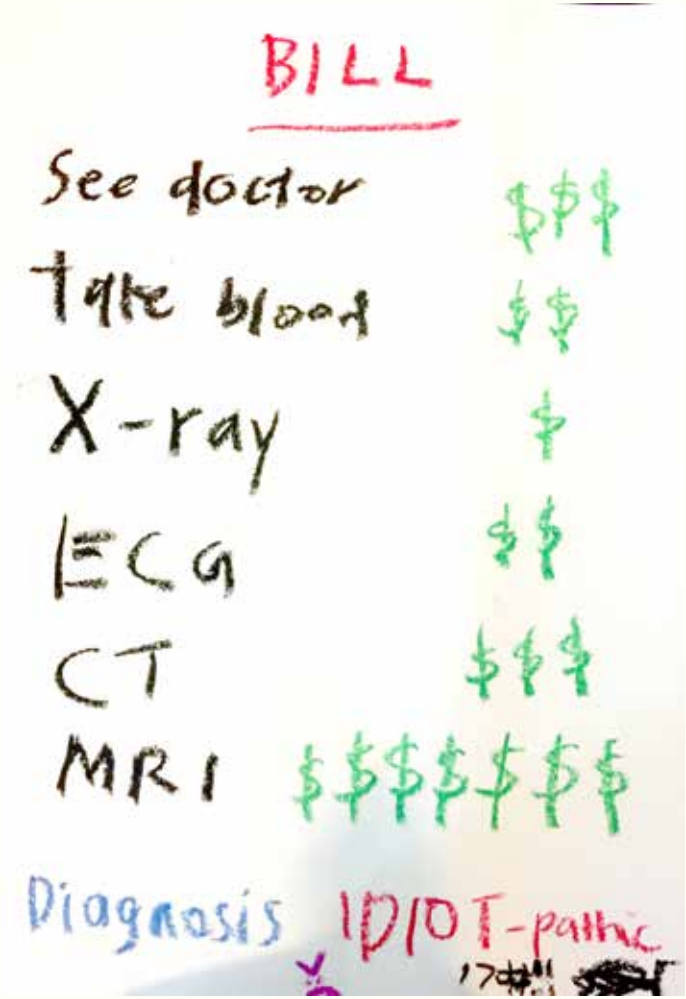
BILL
See doctor $$$
Take blood $$
X-ray $
ECG $$
CT $$$
MRI $$$$$$$
Diagnosis IDIOT-pathic

WHO'S THE BOSS?

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

Commentary

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

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

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

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

— Dr. Tan See Leng

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Doing Good and Beyond

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

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

— Dr. Ong Chooi Peng

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

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REGULATORY MATTERS

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

Commentary

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

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

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

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

— Dr. Wong Chiang Yin

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Brave New World

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

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

— Dr. Wong Chiang Yin

ELECTRONIC MEDICAL RECORDS

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

Commentary

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

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

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

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

— Dr. Wong Tien Hua

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Information Technology and the Doctor

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

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

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

— Dr. Lee Yik Voon

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PROPER AND IMPROPER INFLUENCE

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

Commentary

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

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

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

— Dr. Lee Pheng Soon

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The Drug Rep

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

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

— Dr. Lee Pheng Soon

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MEDICAL ADVERSE EVENTS

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

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

Commentary

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

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

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

— A/Prof T. Thirumoorthy

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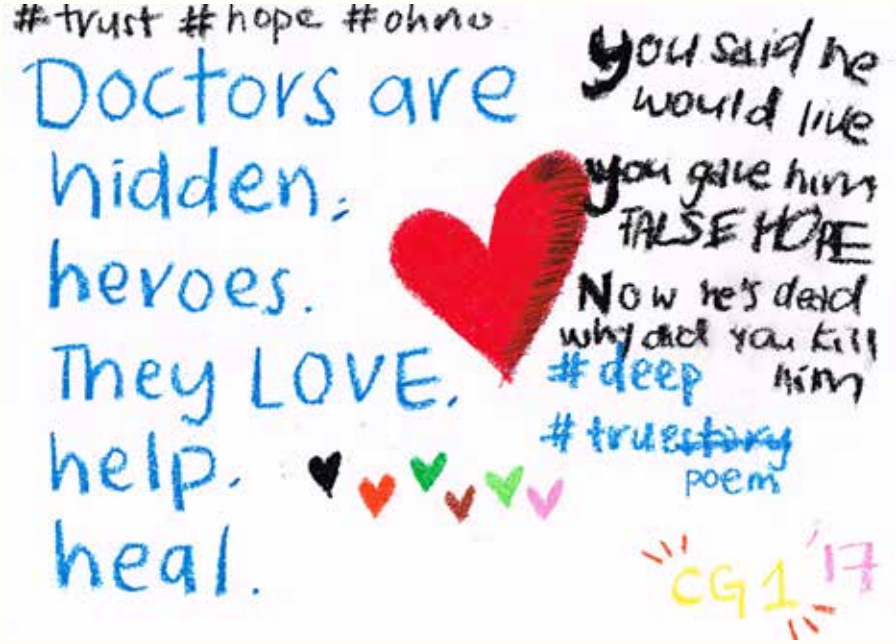

Treading on Eggshells

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

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

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

— Dr. Ong Chooi Peng

OCCUPATIONAL RISKS

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

Commentary

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

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

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

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

— A/Prof T. Thirumoorthy

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

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

WORK-LIFE BALANCE

Mummy daddy don't go to work!

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

Choices

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

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

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

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

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

— Adj Assoc Prof Tan Tze Lee

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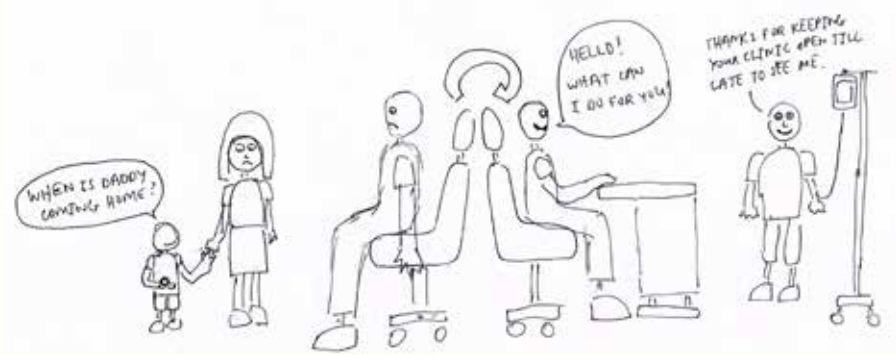

The Broken Window

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

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

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

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

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

— A/Prof Cheong Pak Yean

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WORK-LIFE BALANCE

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

Balancing Act

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

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

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

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

— Dr. Ann Toh

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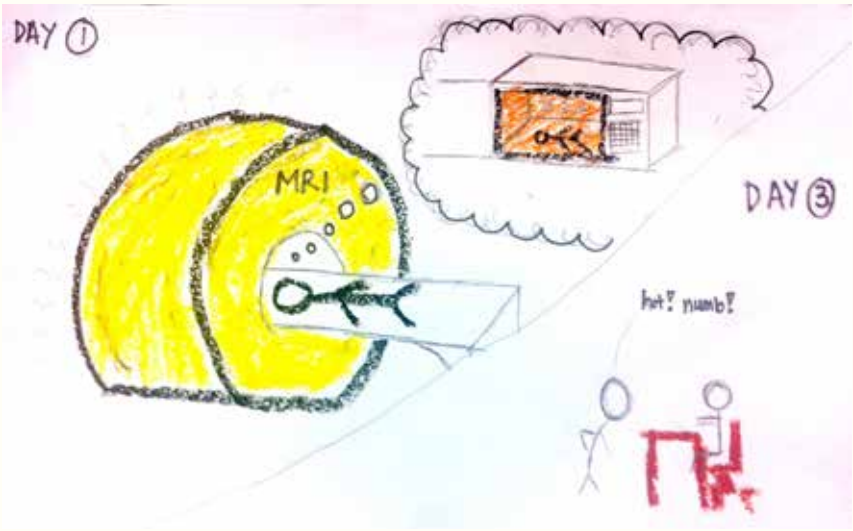

Lunch break!

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

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

I am busy, I am.

— Dr. Ann Toh

WORK-LIFE BALANCE

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

— Amelia Burr

More Choices

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

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

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

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

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

— Dr. Ann Toh

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Me *Time!*

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

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

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

— Dr. Ann Toh

DOING GOOD AND (NOT) HARM

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

Commentary

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

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

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

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

— A/Prof Cheong Pak Yean

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

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The Heart That Would Not Stop Beating

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

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

— A/Prof Cheong Pak Yean

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PHYSICIAN, HEAL THYSELF

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

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

Commentary

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

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

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

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

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

— A/Prof Goh Lee Gan

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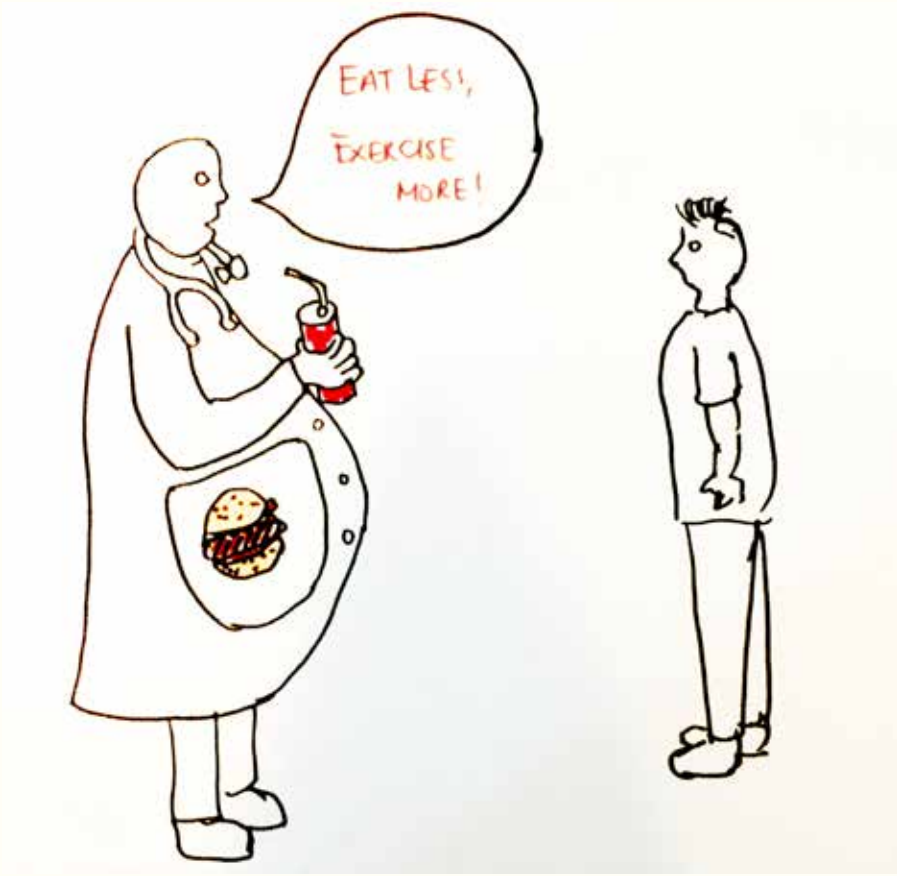

One-Act Play

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

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

— A/Prof Goh Lee Gan

LIFE IS A JOURNEY

Life is a journey, not a destination.

Many of us come to this realisation over time.

Commentary

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

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

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

— A/Prof Goh Lee Gan

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*Ars Longa, Vita Brevis**

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

Two ideas are drawn here.

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

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

— A/Prof Goh Lee Gan

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

ART AND SCIENCE

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

— Sir William Osler

Commentary

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

Perhaps the two are the sides of the same coin.

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

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

— A/Prof Cheong Pak Yean

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Calligraphy by Phoong Zhia Ying

Gentle Epiphanies

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

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

— A/Prof Cheong Pak Yean

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