# Interview with Duke-NUS Graduate Medical School Singapore Students

Interviewed by Dr See Toh Kwok Yee, Editor

As a follow-up to the Sreenivasan Oration delivered by Professor Ranga Krishnan, Dean of Duke-NUS Graduate Medical School Singapore on "The Greying World", The College Mirror has decided to interview two of its medical students who are currently in the midst of their Family Medicine posting.

To recapitulate, Prof Ranga has, in his insightful speech, mentioned that integrated solutions to the heathcare problems of an aging population are critical and that Family Medicine and Family Medicine practitioners can be the building blocks. It follows then, according to Prof Ranga, family care physicians are now at the top of the wish list from most healthcare systems.

It was with this timely speech in mind that the views of these two graduate students were sought.

It has started as a structured interview but the interviewer soon realised that such a format would not do justice to these young enthusiastic minds who were raring to share their thoughts and experiences beyond the usual questionnaire.

Consequently, the decision to let the two 'speak their minds' has produced the following refreshing articles.

*Ms Melissa Tan, a Singaporean, pursued her undergraduate education at the University of Michigan, majoring in Neuroscience. According to Melissa, along her "clinical journey", she has been inspired by mentors who treated their patients together with their families holistically thereby adding life to the patients' years and not simply years to their lives. She is the current Honorary Treasurer of the 5th Student Council and is looking forward to contributing in the field of palliative medicine.*

The "greying problem" - we often term this societal phenomenon of an aging population a problem. The fact that communities reject nursing homes built in their backyards, elderly lack caregivers, and an increasing number of elderly are suffering from depression are problems, but the elderly themselves are not. In a recent New York Times article "older people become what they think", it highlighted studies that showed when the elderly are exposed to negative stereotypes, and become convinced that ageing is burdensome, they have shorter lifespans and worse cognitive functions. That, I believe, is a problem.

In my journey through the family medicine curriculum, I have had the privilege of adopting Uncle T as my family medicine patient. He is a patient that hospitals dread to see and term as a "frequent flyer", with a whopping record of 10 admissions over the past year. Uncle T has a complicated medical history of diabetes, hypertension, hyperlipidemia, ischemic heart disease, recurrent falls, and the list goes on. His medical history made him an excellent choice as a family medicine patient, but I had no idea that his social issues went longer than that. The first time I stepped into his one-room flat, I was overwhelmed by the smell of urine and faeces. Uncle T lives alone since he was widowed 8 years ago has limited mobility and spends most of his time in his bed, wheeling himself to the hawker centre downstairs for meals once to twice a day. Uncle T's warm welcome always makes me smile, yet listening to him share his family issues (he has 5 children, with only one daughter who is officially involved in his care but difficult to contact) and the sense of resignation I get from him breaks my heart (the phrase I have heard him repeat most in Chinese is "I am old, it is troublesome"). During one of my visits, I ask him about his health, and he says "same old", insisting that he takes his medications. A sun image on the pillbox means to take in the morning, the moon means to take at night, he tells me. However, the pillboxes with the sun on it looked untouched (he said that they were refilled just), and the pillboxes with the moon on it are empty (he said he had finished taking them just). Yet the many medications in the SGH pharmacy plastic bag were left unopened. I sighed, not knowing which to believe. And he had insisted once again that he was coping. He had refused the multiple applications the social workers have put in to request for home help, and without his agreement, the medical teams are always in a pickle with regards to his home care. I have watched Uncle T bounced back and forth from hospital admissions, usually due to complications from his non-compliance to medication or due to falls. My biggest challenge in this case was how I could help him regain his dignity and independence. As I ponder this, I realised that it wasn't about what I could do or buy for him, but it came down to changing my perspective of the elderly, as much as changing his perspective of himself and his illness. He needed to know that he should not feel devalued and see himself as a burden.

My experience with Uncle T has shown me the neglected side of our society. He is one of the many who are forgotten and have fallen through the cracks. I am excited for the initiatives that are coming up by the time I graduate. Schemes and approaches like the Grand Aide System and the Ageing-In-Place programme are necessary and important. More than that, I appreciate that these new initiatives aim to care better for our elderly by building deeper relationships with them, through health care teams, their communities and fellow more able elderly and always keeping the totality of the human person in mind.

Uncle T is still caught in the web of paperwork, nursing home applications, and assessments to determine his decision making capacity before he is able to live in a safe environment. However, to accord him a quality of life and to empower him to better manage his comorbidities, I believe that helping him feel valued again is the first and all-important step. I have learnt that healthcare workers need to reinforce the positive aspects of aging. To this end, I like to quote Dr Becca Levy, a psychologist working on aging and stereotypes, *"If all of us became a little more aware of the implications of our communications — the tone of voice we use with seniors, the attitude we adopt, the use of loaded phrases or expressions, the extent to which we give older adults our full, undivided attention — that would help quite a lot."*

*Ms Zhu Guili hails from Jiangsu, an eastern coastal province of the People's Republic of China. Upon graduating from the National University of Singapore with a major in the Life Sciences, she has spent a two-year stint at A*STAR before joining Duke-NUS GMS. She is married and is looking forward to becoming a mommy in the coming months.*

I come from China, a country with a very different medical care system. Nevertheless, it is an era where almost the entire world is seeing an ageing population, be it Singapore or China. To be honest, I'm very envious of the established integrated care provided by Family Physicians in Singapore. In China, the elderly patients, who commonly have multiple co-morbidities, see different specialists for diseases arising from different systems. The consequence is increased health cost, inconvenience and a fragmented healthcare where each specialist only takes care of his area of interest and no one actually looks at the patient as a whole. I see the success of family practice providing integrated care in Singapore, and I foresee Family Medicine leading the way similarly for the rest of the world.


From left: Ms Melissa Tan and Ms Zhu Guili.
*Image courtesy of Dr See Toh Kwok Yee.*

As third year medical students at Duke-NUS, we go through a 10-month clerkship in Family Medicine. The curriculum is designed such that we get to experience diverse aspects of Family Medicine. Each of us is attached to both a polyclinic and a private GP clinic. A substantial proportion of the cases are elderly patients with chronic illness, and I was taught the ABCDEF model of chronic care, which aims to detect and care for all healthcare gaps of the patient, be it acute or chronic, physical or psychiatric, current or predicted illness. I especially loved the sessions in the private GP setting. My GP mentor runs a family practice in the mature community for many years. Apparently he knows his patients and their families very well. It is common to see two patients from the same family, who take turns to sit in the patient's seat for consultation. The trust that patients have in him has definitely pushed for a better therapeutic relationship.

I remember this particular case I saw which involved an elderly lady who had recently completed her treatment for lung cancer and was flying off to Thailand in a couple of hours. She had a cough that was bothering her but during the consultation it was established through clinical findings that she had chest infection. Despite her eagerness to travel as planned, she had decided to follow her family doctor's advice and gave the trip a miss. If she had not trusted him so much, I am sure she would have gone ahead. Besides the good doctor-patient relationship that I really enjoyed, I also had ample opportunities to clerk patients and practise clinical skills. While we have other commitments as third year medical students, such as a research project and the compulsory United States Medical Licensing (USMLE) step 1 exam, the posting in the family medicine clinics allows me to keep in touch with my clinical competence.

Besides the clinic attachment, our family medicine curriculum also included a module called patient-centred care. Each of us follows up two patients, beginning from their hospitalisation for a period of 10 months. The home visits allowed me to see the patient in a more realistic setting; where the patient spends most of the time. I could see the home environment and modifications that have been done to suit the needs of a particular patient. Experiencing the family dynamics first hand allows me to witness and assess the adequacy of the the patient's relationship with his family members in helping his medical conditions. I find it very fulfilling to establish a close relationship with the patient and his family over time and when they open up and share about their lives which usually do not happen in the hospital setting. Healthcare does not stop the moment a patient steps out of the hospital or clinic. It continues at home. We, the healthcare providers, should definitely take these home visits as an opportunity to improve chronic patient care further.

The pivotal role of family medicine in caring for a "greying population" that Dean Ranga mentioned cannot be overstressed. With our family medicine curriculum, I hope to be better prepared for the future medical landscape in Singapore.

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