Burden of Care

By Dr Tan Poh Kiang, Editorial Board Member

There are good days and there are bad days in a GP's life. I think of good days as when the flow of patients is optimal such that I sense much work done without feeling fatigued from hurry. Good days comprise moments when the right decisions are made toward accurate diagnosis and effective treatments. Even better yet, good days are when tangible appreciation is expressed by patients whom I had devoted much energy to provide care.

The reality is that a doctor's daily experience is a mixture of laughter and tears – the sweetness of the conquest of disease, and the agony of being stumped by the same enemy to the point of feeling helpless.

Bad days can begin even with waking on the wrong side of the bed. There are those blues that colour the days when I have to explain to irate employers why it costs them so many dollars to treat their lowly maids. But there is one particular bad day that felt like a blunt trauma to the thorax, leaving one gasping for breath and yearning to take a break from clinical work. I shall describe one such day.

MORNING BLUES

My clinic opens at 9am. After the first 15 minutes of patient registration and other preparations by the clinic staff, I commence seeing my first patient. On that day, I was greeted by my assistant with a request to visit one of the elderly patients whom I had seen two weeks earlier when he developed a fever and cough. When he did not respond to the Klacid MR that I had prescribed, the family admitted him to Singapore General Hospital. After five days of intravenous antibiotics, his symptoms abated and he was discharged. Two days later, however, he left for another world – he was found dead earlier that morning by his maid.

Mr Low was one of the most courteous men I had met. Although old enough to be my grandfather, he was always quick to greet me the moment the door to the consultation room was opened. He had a habit of thanking me profusely after each consultation. Six months prior to his death, he had suffered an unexpected but massive stroke, leaving him immobilised, confined to the wheelchair and devoid of speech. His eyes did all the "talking" whenever he visited the clinic after that stroke. I could still read gratitude and politeness in his face at each of the visits. The difference was an overt cloud of sadness – he would much rather thank me in words than nods and blinks. His freely flowing tears were particularly moving.

So it was with a very heavy heart that I pronounced him dead from bronchopneumonia. My consolation was that he had died without much suffering. It was a good way to leave, I told myself.

The morning session ended with the wet market egg seller, Mrs Chan asking to see me in between waiting patients. Apparently, Mr Chan had been admitted a few days before when he had slumped over at the dinner table. He was another victim of a cerebral vascular disease, albeit not surprisingly so. Unlike the thin and health-conscious Mr Low, Mr Chan loved all food sinful viz. pig trotters, oyster omelet, mutton soup, fried kway teow and laksa. He never controlled his diet despite his horrendously elevated LDL-cholesterol, hypertension, gout and ischaemic heart disease. He lived life with an abandon even though he had been in and out of hospital for crippling gouty arthritis, congestive cardiac failure and a previous stroke two years ago. He laughed whenever I warned him sternly about his reckless lifestyle. He even begged other wet market stall-holders for cigarettes whenever he could, since his wife and sons refused to purchase them for him.

What Mrs Chan needed was a letter from me to inform the ward doctors that it was her and her sons' decision that if he collapsed (he was on DIL – Dangerously Ill List), they would opt for no resuscitation (DNR). Although I had failed to persuade him to change his ways, I had grown to admire his carefree attitude and zest for joyful living. So it was with deep sadness that I had penned that required memo.

MORE BAD NEWS

A burdened heart does not make for a great appetite. After a light lunch that day, I met a young lady patient whom I saw

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for the first time. Her problem of tension headache was a no-brainer, but when she revealed the underlying cause, I knew that the analgesics I had intended to prescribe were not going to help very much. Edith's mother had been a patient of mine for years. She had consulted me for various minor ailments over the years but three weeks ago, I recalled seeing her for a prolonged fever. Despite my treatment, the fever was unremitting and she had to be admitted. During the admission, initial suspicion of dengue fever gave way to acute cholangitis when she became deeply jaundiced. The investigations revealed a stone in the common bile duct causing obstruction and complication of jaundice and infection. The first ERCP failed to relieve the obstruction and caused significant bleeding. The general surgeon was approached but declined to operate on her because of her age, diabetes mellitus and thrombocytopenia. She was in a coma and moribund. A second ERCP was scheduled.

Edith wanted to know if there was any possibility of mismanagement. She also enquired if she ought to transfer her mother out of the government-restructured hospital to a private one. I took time to explain the situation and dissuade her from transferring her mother. After she left, I found it most difficult to smile for the rest of the day.

As if the day had not been bad enough, the night session ended with a referred case from the neighbourhood family social service. Madam Hasnah complained of a right chest pain that had also caused weakness of the right arm. A clinical examination quickly revealed a 4cm hard mass in her right breast. I was almost certain that it was a malignant lump I had felt. I was even more astounded when I found out that she had already felt the lump four to five months ago.

"Why didn't you see a doctor earlier?" I asked in exasperation.

She sheepishly admitted that she had no money and was worried of being admitted to the hospital since she was a single parent with three school-age children. I called the social worker responsible for her case to insist that she be brought to the polyclinic for a referral to the surgical department for definitive treatment. I had a hunch that what was an early stage curable disease had since progressed to an advanced, incurable stage.

That day left me drained and depressed. It would take a few days before I regained my usual cheerfulness.

THE REALITY OF MEDICAL PRACTICE

What is the point of this lament? I need to disclose the unglamorous side of clinical practice. I admit that I was drawn to medicine by the success stories of lives saved, limbs salvaged and bodies healed. It is the natural drift of society to choose to tell only success stories.

However, the reality is that a doctor's daily experience is a mixture of laughter and tears – the sweetness of the conquest of disease, and the agony of being stumped by the same enemy to the point of feeling helpless. I submit to the younger doctors that the duty of care extends to the burden of bearing the sadness, anxiety and despair when medical solutions are found wanting. After the initial shock and denial, patients and family members will come to accept the inevitable outcome of a grave illness. What can buffer the pain is the doctor who can empathise with their suffering. The burden of care is uncomfortable to the doctor, I must confess, but it is certainly a necessary medicine for the sufferer when all else fails. ■