



Reflection on Tan Tock Seng Hospital Clinical Fellowship Experience

By Dr Khalilah Bullock

Before meeting the Head of the Emergency Department at Tan Tock Seng Hospital (TTSH), Associate Professor Eillyne Seow, at the ICEM 2008, I had never dreamed of visiting Singapore for anything other than tourism. However its strategic location at the hub of South East Asia and unique status as an English-speaking, safe, multicultural society that claims to have achieved tolerance between people of diverse backgrounds attracted me, but it was over one year before I was finally able to arrive here.

Articles in the mass media and journals highlight Singapore's healthcare system as well-organised and planned, cost-effective, and on par with the standards of other developed countries. Having been exposed to the emergency healthcare system of the United States via the media, during the course of a one-month research elective, and through

United States postgraduate trainees who passed through my parent Emergency Department (ED) on their own electives, I was excited by the prospect of exploring a novel environment. Research on TTSH specifically showed that it housed the busiest emergency department in Singapore due to its central location, supported postgraduate trainees, utilised up-to-date technologies and equipment, was a major centre for trauma management and life support training, and attracted medical tourists within the region.

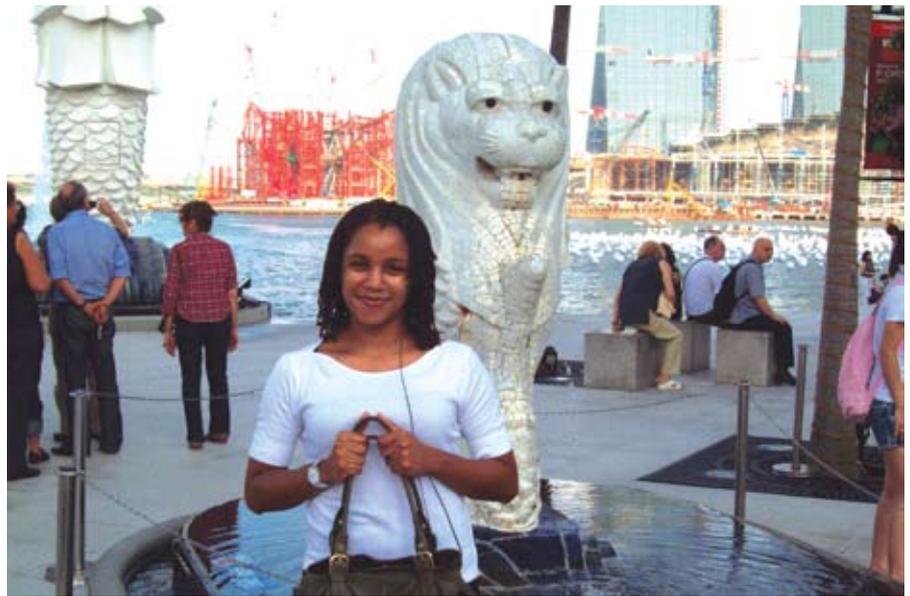
After making contact with the emergency department at TTSH, with the aid of Dr Kenneth Heng, the residency director, I was able to apply successfully for a six-month posting. Now that I have completed my fellowship I can honestly say that while being challenging and sometimes difficult or distressing, this elective experience has definitely been worthwhile.

LEARNING EXPERIENCES

- Exposure to Different ED Workflow Plans, Protocols and Management Structures
 - o In this ED, established written clinical pathways and protocols attempted to simplify and facilitate the management of common conditions and enhance patient safety. Great emphasis was placed on idiot-proofing the workflow. I gained an appreciation of the principles behind these plans which would enable me to adopt some of them when I return home.
- The concept of the ED as a business unit was new to me. I gained some appreciation of the role, along with the advantages and disadvantages, of the Head of Department as the "boss of all bosses" within her Department. This includes the medical, nursing, clerical, ancillary, and other staff.

personally speaking

- Exposure to Observation Medicine
 - As my parent ED does not operate an observation ward, I was happy to review the protocols of the Emergency Diagnostic and Therapeutic Centre (EDTC) and attend clinical rounds there. In addition, through my connections from TTSH, I was able to view observation wards in Bangkok, Thailand and Melbourne, Australia.
- Exposure to the Emergency Medical Services (EMS) via Singapore Civil Defence Forces (SCDF) Dispatching Centre Tour and Ambulance Attachment
 - As there is no nationwide integrated ambulance system in Jamaica, it was instructional to tour the Singapore Civil Defence Force's Ambulance Dispatch Centre and learn how emergencies of different types and scales are handled. The attachment allowed me to participate in the emergency response and transport process and glimpse various aspects of civilian life in Singapore; it also provided excellent medical and sociocultural exposure.
- Exposure to other Healthcare Facilities
 - I was able to tour Jurong Polyclinic, hosted by Dr Benjamin Cheah, and the Rajavithi Hospital in Bangkok, Thailand under the guidance of Dr Pairoj Khruengkarnchana and Dr Nalinas Khunkhlai, through my contacts at TTSH. This allowed me to see different models of primary and emergency healthcare institutions from those in my country. During my hospital tour in Bangkok, I was able to view the hospital-based ambulance dispatch system, the simulation training lab and to audit one of the postgraduate training lectures.
- Exposure to Disaster Plan and Protocols
 - Not only did I learn about the hospital and national plans for different types of disasters, but



Khalillah with Baby Merlion

having arrived on the tail of the initial phase of the Influenza A “Swine Flu” H1N1 outbreak, I was exposed to the infection control procedures in action.

- Exposure to Orientation and Training Modules
 - Before starting work, I was surprised at having to formally demonstrate my proficiency at using basic equipment such as a urine dipstick, a glucometer, and a urine pregnancy test kit. I also enjoyed seeing how introductory training modules and tests for junior staff beginning a rotation through the department are conducted, including lectures and practical skills tests (such as suturing, backslab application and so on). I realised the value of such a meticulous approach in ensuring that everyone is able to perform basic procedures at a known acceptable skill level within the department. The series of lectures for the medical officers each month was also interesting. One of the most memorable lectures was delivered by Dr Phua Dong Haur and addressed cognitive errors that physicians are prone to, as I found myself referring

mentally to it throughout the elective. The high workload and other stressors in the emergency department increased the risk of medical errors, and the integrated information technology systems in use combined with the vigilance of the senior staff increased the awareness of these errors when they occurred.

- Exposure to Local and Central Specialist Training Sessions and other Learning Opportunities
 - Through attendance of these sessions, I gained exposure to how trainees at the basic and advanced specialist levels are prepared for examination. My favourite module was the Introduction to Health Services Research module and I hope to be able to apply the basic principles I was exposed to in future research.
 - I was privileged to receive sponsorship through the Associate Dean's Office to attend the annual Clinical Quality Improvement Conference, and international speakers provided a valuable introduction to the clinical quality assurance processes in their countries through this two-day conference.

- o In addition, I was able to complete my Advanced Cardiac Life Support (ACLS) recertification and attend a practical Biostatistics and Clinical Epidemiology Seminar, both hosted at TTSH.
- Availability of Mentors
 - o The ED consultants, such as Dr Lim Ghee Hian (Disaster Planning), Dr Lim Beng Leong (Research) and A/Prof Eillyne Seow (Emergency Medicine Leadership and Administration) made themselves available to me in their free time to discuss important subject areas that I expressed an interest in. Other ED consultants served as positive and negative role models at different times when I worked shifts with them during the elective. This was important to me, as I had previously worked in a smaller ED staffed with only five postgraduate trained emergency medicine consultants.
- Developed Grudging Appreciation for the Applications of Information Technology in the ED
 - o My early experiences with the ED Web were time-consuming and fraught with many documentation errors. I would spend ten minutes clerking the patient and then thirty minutes or more trying to figure out how to enter the notes and orders, and how to generate the appropriate forms to dispose of (admit or discharge) the patient! With experience I became somewhat more proficient with ED Web and learned to appreciate some of its advantages, such as the ability to retrieve laboratory and radiological results as soon as they were ready, as well as have access to previous records.
- Nurses
 - o Overall, I enjoyed interacting with the nursing staff at TTSH. I found them helpful,

The official administrative language of Singapore is English. However many patients who utilise the emergency department, local and foreign, are more proficient in other languages. Furthermore, both locals and foreigners who have lived in Singapore for some time often prefer Singlish – the local pidgin English dialect. I was actually scolded by a local patient for speaking (English) in a “foreign way” then rescued by a foreign nurse who spoke to the patient in Singlish!

knowledgeable, and proficient in their tasks. They were very assertive, and were quick to detect and highlight potential errors. They are also quite willing to scold when they feel that something was not being done properly but on the other hand, they are usually quick to offer assistance, and their knowledge of local languages, culture, and clinical protocols saved me on many occasions.

Singapore for some time often prefer Singlish – the local pidgin English dialect. I was actually scolded by a local patient for speaking (English) in a “foreign way” then rescued by a foreign nurse who spoke to the patient in Singlish! I frequently relied upon the nurses and other staff for Mandarin, Malay and Tamil translations. For foreign patients such as those from Thailand, Vietnam, Bangladesh, and Myanmar, I often relied on aid from their companions and very simple English with abundant hand gestures.

NEGATIVES

- Less responsibility and autonomy in clinical decision making
 - o Coming from an ED in which I held a senior post with supervisory responsibilities towards medical students and junior doctors to a post where I had considerably less autonomy in my clinical work was frustrating at times. Being a clinical fellow meant having to assume a much less assertive role than usual when communicating with colleagues as well as clients, and occasionally executing management plans contrary to my own preference and clinical instincts.

Communication Styles

- o I realised that the patients and their next of kin were very assertive and blunt in speech. Those who came with preconceived notions of the evaluation and treatment they should receive stated their demands readily, often instead of providing a history of the presenting complaint. Patients or caregivers would state their opinion as to whether H1N1 flu tests, blood tests, radiographs, and admission were necessary and then protested adamantly if the doctor disagreed. They easily made statements that I considered inappropriate. For example, during one consultation with a patient and his girlfriend they told me that they had seen black people before in Miami, and they thought that black people danced

INTERESTING EXPERIENCES

- Language Barriers
 - o The official administrative language of Singapore is English. However many patients who utilise the emergency department, local and foreign, are more proficient in other languages. Furthermore, both locals and foreigners who have lived in

funny. They then asked if I could show them how we dance – all in a normal conversational tone of voice! On the other hand, this frankness and assertiveness was sometimes positive. I felt both amused and encouraged when a patient's relative corrected my pronunciation and instructed me on what television channel to watch in order to improve my fledgling Mandarin.

- o Social niceties were often omitted by patients. Words like “please” and “thank you” were commonly used to urge speed and add emphasis to commands or demands rather than to add politeness.
- o Many patients seemed to prefer short questions and explanations. They would otherwise express impatience or request clarification and repetition. I was able to identify a few key words, which facilitated communication. These included the magic word “can”, which apparently meant “please do it”, “I will do it”, “I agree”, “are you in agreement?” and “do you understand?” and did not solely address whether something was possible. Another example was the word “have” or alternatively, the word “got” which took on the additional meaning of “yes, I do”.
- A Different Kind of Foreigner
 - o In Singapore, people were initially very reserved and often appeared uneasy with or slow to warm up to me. As a Jamaican of African descent with sister-locked hair, I represented a unique kind of foreigner. I frequently noticed people staring openly at me in public places. Greetings to passers-by were not regularly returned by strangers, even in my apartment building or at work during my first two months. These reactions made me

uncomfortable as I had lived in a society with different social norms in which my race or appearance was not special as I blend with the gross majority. A few people, usually elderly Chinese who spoke English and other foreigners, were direct in expressing their curiosity about me. I had a few good conversations with these perfect strangers who wanted to know where I was from, to share their own knowledge of my country's achievements (track stars, beauty queens, and Bob Marley), or to share their own experiences of foreign travel. My hairstyle became an icebreaker as people approached me to ask how it was maintained or whether they could touch it. Interestingly, outside of work, I was sometimes randomly approached or greeted by Indian people. One Indian lady told me that our skin was the same colour and therefore she was Jamaican too. I was sometimes addressed in Malay, and later learned that people of African descent with locked hairstyles are not as uncommon in Malaysia as in Singapore.

- o The majority of patients and their relatives were amenable to being evaluated and treated by me once they realised I was the doctor. Others expressed their discomfort in various ways. Some patients insisted on a “Chinese-speaking doctor”, including twenty-year-old Singaporeans serving National Service (NS) who ought to have been proficient in English. This occurred even when Chinese translators were available. In this I was not special as I noticed that other members of staff, particularly the Filipinos, occasionally received similar requests.
- o Some of the patients attempted to interview me as to where I was from, my purpose and length of stay in Singapore, whether I was a trainee, and whether I was from India or Africa instead of disclosing

their clinical complaints. Their level of satisfaction usually seemed to diminish if I disclosed that I did not plan to become a permanent resident and had only been in Singapore for a few months. One unhappy spouse even asked me what my age was, how long ago I had completed medical school and in which country (following the whole gamut of other questions), before requesting that her husband be seen by a senior doctor. Fortunately the ED staff quickly became accustomed to me and supported me in unpleasant situations.

- National Service
 - In Jamaica, there is no group of patients like the young men serving NS in Singapore who can receive healthcare without payment at local hospitals and polyclinics. The health-seeking behaviour and conduct of the NS men were sometimes interesting or disappointing. They were most likely to present to the fever area with upper respiratory symptoms, usually during their weekend breaks. While they sometimes had valid and serious complaints, many attended for non-acute or trivial complaints that should have been well within the capabilities of a camp medical officer (MO) or family practitioner. The ones who came to hospital with minor illnesses usually expressed a reluctance to be seen by their camp MO. They would explain that they came to hospital because they could not contact their supervisor for permission to see the camp MO, did not think he was skilled enough, or felt that he would give light duty or just medicine instead of a medical certificate (MC). They usually requested medical leave even contrary to the judgment of the treating physician. There were certain NS men who could be considered “regulars” at hospital. One of them stood out because he wore the uniform of a popular fast food restaurant each time I saw



Khalilah at her farewell dinner near Robertson Quay.

CONCLUSION

On returning home to work as an emergency physician, I realise that I am still assimilating the depth of experiences I gained in Singapore both professionally and personally. The things I will miss the most about working at TTSH are the consistent, effective team dynamics and the people there who befriended and assisted me. I will miss the feeling of public safety I experienced in Singapore. It allowed me to fearlessly rely on public transport and walk on the streets very early in the morning or late at night. I will also miss the multicultural environment of Singapore, learning and listening to the local languages, and being able to purchase tasty foods like Hainanese chicken rice at practically anytime and anywhere.

I am looking forward to discovering how the things I learned can be applied in my local work environment. I will explore the design of fool-proof staff training protocols and workflow and find ways to incorporate health services research ideas and quality improvement principles in my work. Although I anticipate resource difficulties, and in spite of my stormy relationship with the ED Web, I still find increased application of information technology in medical record organisation and storage desirable. Now that I have returned to a practice environment in which my qualifications will readily allow me to assume a leadership role, I can practise some of the tips I received from my mentors. I am looking forward to sharing my experiences of TTSH and Singapore with friends and colleagues who will want to know “what’s so good about Singapore?” and what qualities facilitated the rise of Singapore from a developing country, like Jamaica, to the thriving metropolis it is today. **SMA**

him, and I had seen him twice for the exact same complaints within a week. On reviewing the available past emergency department records of this healthy-looking young man, I realised that he had presented to TTSH and another hospital about once to twice per week for the past two months. He had a similar pattern of attendances at Changi General Hospital before that, and according to the history of his past MCs he would have spent more time on medical leave than in NS over the past few months. The behaviour of one NS man struck me as particularly unpleasant. This young man came by taxi early one Sunday morning carrying cigarettes while his companions, who were visible at the waiting area outside, carried beer containers. He became loud and verbally abusive to the doctor seeing him (the nurses later explained that he was cursing in Hokkien) when he was found to be in adequate physical health and denied MC. He then changed his physical complaint and insisted on being seen again by a different doctor and he refused on site observation that was offered before the second doctor also informed him that he seemed healthy and should follow up with his camp MO.

- Value for money
 - o The patients whose presenting complaints attracted low triage acuity all seemed to have a back-up shopping list of other non-acute complaints. I have seen a number of patients who kept adding on seemingly minor complaints each time I was attempting to end a clinical session. These complaints often were not distressing to the patient and were of long duration. When I questioned my colleagues as to whether they also noticed this, they theorised that it was a local cultural imperative for patients to maximise the benefits gained for the consultation fee paid (this was also stated as the principle that things should be cheap and good), particularly if their main complaint did not require serious intervention. I remember one gentleman explaining to me upfront that the fee was really too much but he had missed the opening hours of his nearest clinic, and therefore wanted three refills of his regular topical analgesics, extra bottles of cold medicines, and also felt that he deserved two days of medical leave (although he also said he felt his cold was minor) to maximise the value of the fee paid.



She is interested in clinical research – particularly injury prevention and health services research – as well as emergency medicine administration. Her hobbies include reading, gardening, and open water diving.