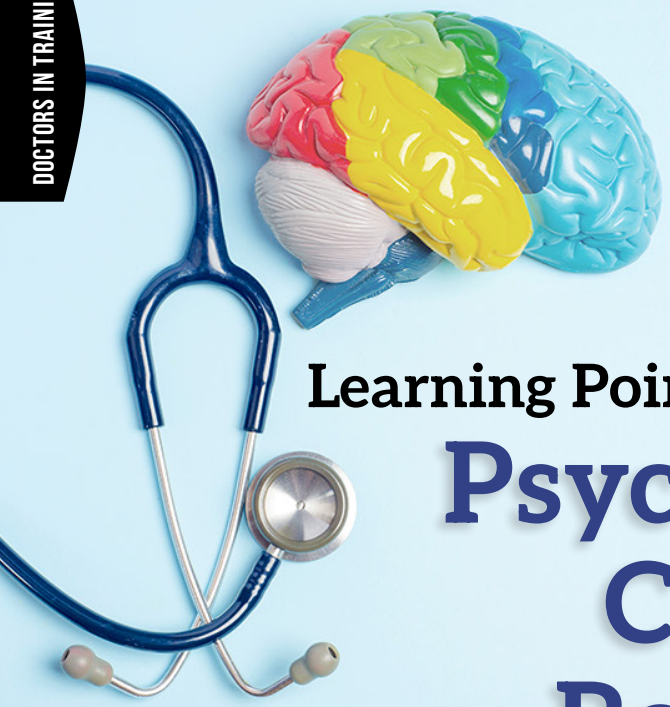

Learning Points from My Psychiatry Clinical Rotation

Text by Nicholas Chieh Loh

My psychiatry rotation as a fourth-year medical student in the previous academic year was a compelling experience in which I had the opportunity to learn and observe at psychiatric facilities such as the National University Hospital Department of Psychological Medicine and the Institute of Mental Health (IMH).

During the rotation, I witnessed a broad range of conditions, from anxiety and depression to complex cases involving bipolar disorder and schizophrenia. I also observed the psychiatric elements in medical conditions such as delirium in the elderly. These varied experiences have given me a nuanced taste of the psychiatric landscape and an appreciation for the expertise required to manage these conditions.

Opioid withdrawal management in Singapore

One of the most enlightening experiences during my clinical rotation was a morning clinic session at IMH where I learnt about the unique landscape of opioid withdrawal management in Singapore. Contrary to what many international guidelines recommend, methadone is used only in highly specific circumstances locally. This limited application is not due to a lack of efficacy but primarily results from Singapore's hard-line stance on drugs.

Singapore's drug policies are stringent, with a zero-tolerance stance on illicit substances. Trafficking, possession or consumption of any amount of heroin is illegal here.[1] Laws prescribe severe penalties, such as the death penalty for trafficking amounts exceeding 15 g of heroin or 500 g of cannabis.[2] Hence, methadone is tightly regulated in Singapore, though it is often used globally for opioid withdrawal management. This rigid approach contrasts markedly with international practices. In many Western countries, drugs such as methadone and buprenorphine are more widely utilised to manage opioid withdrawal symptoms. The philosophy that informs this policy focuses on harm reduction, aiming to help addicted individuals gradually reduce their dependence on opioids.

The social and legal context surrounding opioid withdrawal in Singapore compounds the complexity of the issue. Potent opioids like heroin are illegal, and there may be a societal tendency to view withdrawal symptoms as a form of "just deserts" for illegal activities. Such a perspective may give rise to a culture that blames the individuals experiencing withdrawal, which can deter them from seeking medical intervention. As such, the cornerstones of local opioid withdrawal management are general supportive measures that address the clinical features of opioid withdrawal as they arise (eg, antiemetics, analgesia, electrolyte replacement and nutritional support).

However, there are specific scenarios where pharmacological treatment for opioid withdrawal is considered permissible, and even "fair", in the Singapore context. These include situations where the patient is seen as "innocent" – such as neonates who could potentially experience neonatal abstinence syndrome, or in people who became addicted to opium before 1946, the year in which the colonial government of then British Malaya instituted a ban on opium.[3] In these situations, the use of methadone or buprenorphine may be deemed acceptable, reflecting a nuanced view that takes historical and ethical considerations into account.

In sum, while the management of opioid withdrawal in Singapore is influenced by the nation's strict drug policies, there are instances where a more compassionate and nuanced approach is adopted. Understanding this complex landscape has been a significant learning point for me, underscoring the importance of considering the local social, ethical and legal contexts of medical practice.

Decision-making capacity

Another eye-opening experience during my clinical rotation involved the concept of decision-making capacity, particularly in an inpatient setting. Though clinicians may sometimes request psychiatric consultations to assess a patient's decision-making capacity, it is important to remember that any certified doctor can evaluate a patient's capacity, especially in straightforward cases.

The evaluation process comprises two key components. The first is determining whether the patient has a disorder of the mind. This initial step sets the stage for the second aspect: assessing the extent to which the disorder affects the patient's ability to understand the situation, retain information, weigh the pros and cons, and communicate his/her wishes effectively. These criteria serve as the foundation for deciding if a patient can participate in decisions concerning his/her healthcare.

Suppose you are a vascular surgeon and your patient has a severe diabetic foot ulcer which has not responded to revascularisation therapy and now necessitates a below-knee amputation. If the patient refuses the amputation, one might think to seek a mental capacity evaluation in the hope that the patient could be declared as lacking capacity. This is such that it would allow one to proceed with the amputation as it would be "in the patient's best interest," as permitted by law.

However, it is important to recognise the ethical and legal implications of such a course of action. Labelling a patient as lacking decision-making capacity is a significant step and has profound consequences. If the patient can understand the situation, retain information, weigh the pros and cons, and communicate, then he/she has the right to refuse treatment, even if his/her decision goes against medical advice. Herein lies a catch-22: automatically equating the patient's contrarian decision with a lack of capacity not only undermines patient autonomy but also puts clinicians in a difficult ethical position. Declaring patients as lacking capacity because they refuse recommended treatment could be seen as circumventing their autonomy, thus creating a situation where the very act of disagreeing might be construed as a reason for their incapacity. This paradox should thus be carefully considered and avoided.

As such, decision-making capacity is not merely a subject confined within the realm of psychiatry, but a fundamental medical issue embedded in the ethical and legal aspects of patient care. This rotation has given me insight into how this complex issue is navigated in the clinical setting, reinforcing the importance of preserving patient autonomy while ensuring that patients are sufficiently informed to make healthcare decisions.

Conclusion

As Carl Jung wisely observed, "The shoe that fits one person pinches another; there is no recipe for living that suits all cases". This could not be truer for psychiatry, a field that demands a nuanced approach tailored to individual patient needs.

Beyond mere academic interest, this rotation will influence my future practice regardless of specialty. The principles learnt here – respect for patient autonomy, interdisciplinary collaboration, and the vital role of social and ethical context – will be fundamental guideposts, especially as I navigate my final year of medical school. ◆

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Nicholas is a final-year medical student at the National University of Singapore. Beyond his current medical studies, he enjoys writing and playing the piano.