# Answering the Call for Aid

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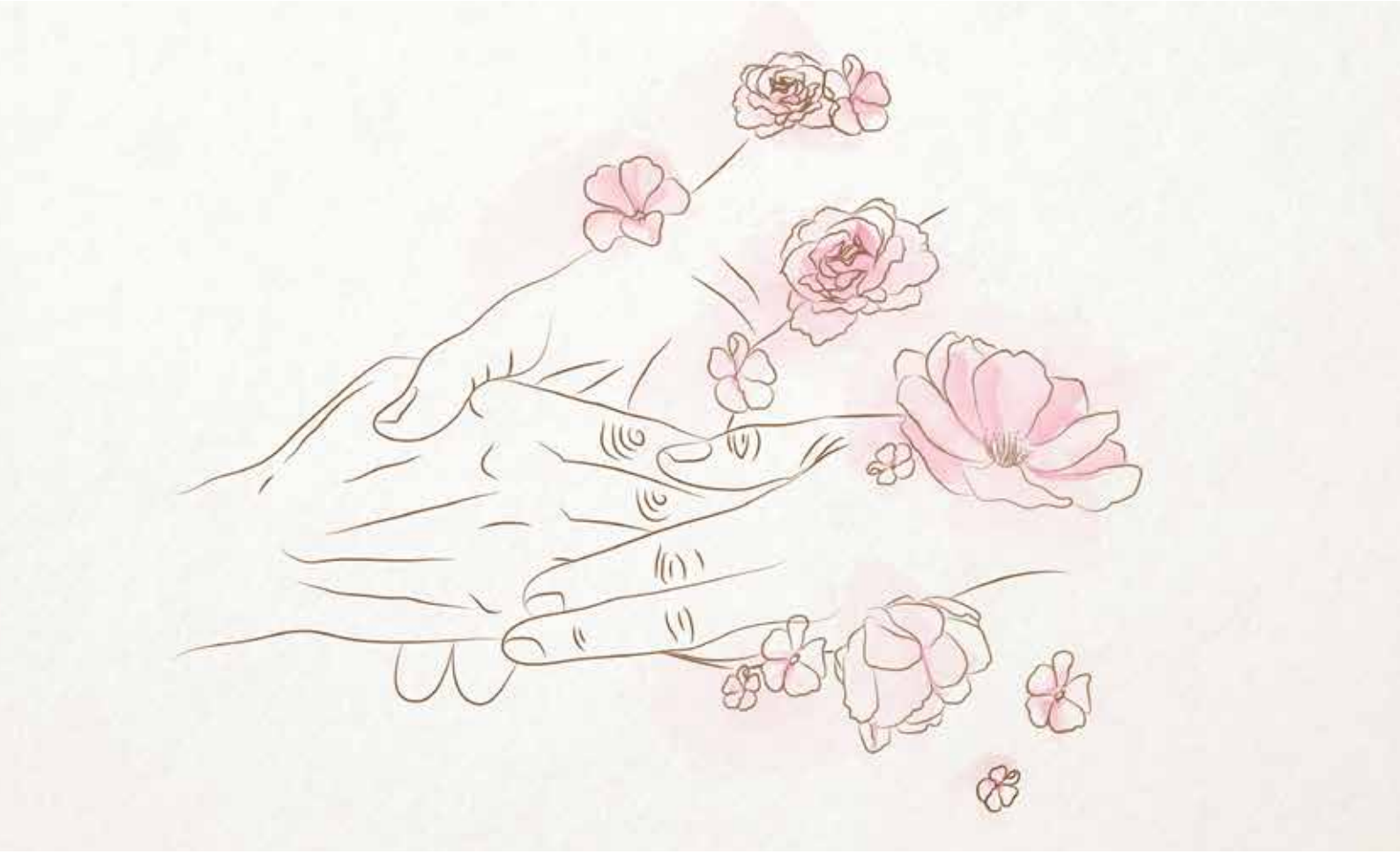

*Names have been changed to protect the privacy and confidentiality of the patients and staff mentioned in this article.*

**THROUGHOUT OUR** years as medical students, we are imbued with the ideals of holistic care, to treat the whole patient and recognise needs and issues that extend beyond their medical problems. Indeed, the World Health Organization defines health as *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"*.[1] It is only beyond the walls of the classroom that one can meet the natural challenges and barriers of achieving this simple aim. For we now live in a time of change. The patients are changing; in the developed world there will be more of the elderly than the young. The needs of patients are changing; people want to be more independent and involved with their care, and also demand more accountability from providers. The science is changing; medical knowledge and recommendations are being revised almost constantly.

Yet from that encompassing view of health and despite our abundance of knowledge, the external aspects of health that involve factors in a patient's home environment and lifestyle, are often inadequately addressed in many health systems around the world. Examples of these factors include: physical hazards at home, social isolation or abuse, and reduced access to health services – that all disproportionally affect the vulnerable and elderly in our community. Transitional care programmes and out-of-hospital follow-ups are deployed today to bridge that gap. As a medical student, I was recently embedded with the community care teams based at Tan Tock Seng Hospital, and would like to share personal reflections on my experience, which is part of my journey to becoming a physician.

## A day in the field

When patients need support after discharge, home care medical teams are sometimes called upon to provide

Photos: Tan Tock Seng Hospital

**From left Physiotherapists assist patients with basic mobility exercises as part of the PACH programme**
**The PACH team provides advice to caregivers, helping them gain the competence and confidence to manage the patients at home and reduce the need for institutionalised care**

**Facing "This illustration emphasises aiding, giving and caring with the use of hand language, decorated with blooming flowers that represents 'Giving Life' through these actions." – Nicole Low**

them with additional assistance for a period of time. After spending a day with one of the Post Acute Care at Home (PACH) teams, I could not help but be reminded of the doctors of yesteryear, who conducted house calls. Eugene Smith's striking black and white images of a doctor practising in a mountainous Colorado community, taken for *LIFE* magazine in 1948, came to my mind. That of a single doctor crossing an open field, dark clouds overhead, wearing tie and jacket, with medical bag in hand. On his face and eyes lie deep lines wrought from experience; his expression is that of gravity and concern.

That day, there were three of us: Dr Lavender, Nurse Cheng and me. Our medical bag was a piece of luggage with plastic wheels, and we found ourselves within a concrete jungle (as opposed to wide pastures). Still, each time the door opened for us, we were greeted with a welcoming smile. We saw three follow-up patients in all.

During each visit, both the nurse and the doctor shared the work: taking vital signs and blood pressure, or tending to bedsores in immobile patients often with advanced dementia. In one instance, I observed Nurse Cheng teaching a caregiver how to monitor for bedsores and change dressings. Some patients had shopping bags full of medications at home; during each visit, Nurse Cheng and Dr Lavender sifted thoroughly through each bag with caregivers, discarding unnecessary drugs. Care and effort were made to ensure that the caregivers were comfortable and capable in their role in supporting the patients.

After returning to the hospital, blood samples were dispatched for investigation and calls were made for referrals or anything else patients might need. When there were tough cases, multidisciplinary meetings would be held to tackle problems and make plans.

"Value for money" is a growing concern in healthcare. And any programme must pass the test of delivering acceptable results for the resources they utilise. With the increased use of multidisciplinary teams and case reviews that incur higher upfront labour hours per patient, one might assume that the PACH initiative would also be costlier to deliver. However this common-sense conclusion might not be the reality. Dr Lavender roughly estimated that each subsidised PACH visit would cost from $115 to $300, and the total charge for ten follow-up visits over three months would be $1,150 to $3,000. In contrast, the general ward charge at a hospital would cost from $42 to $281 daily after subsidies.

In a 2009 news article titled "The Cost Conundrum", Harvard surgeon and medical writer Atul Gawande revealed through a case study that ironically the highest quality and most technologically advanced centres in the USA, such as Mayo Clinic of Minneapolis, Geisinger Health of Danville, Kaiser Permanente of California, actually rank below the national median for Medicare expenditures per patient.[2] He cited one compelling reason: the time and effort taken to manage patients in an interdisciplinary manner. At these institutions, weekly meetings were held to discuss patient cases, generating plans drawn from input across specialties. This process was aimed at setting clear goals for patient care, expediting necessary consults, and most importantly, reducing the number of non-vital tests and interventions that were the main drivers of increased costs.

## Meeting Mr Seng

One patient we visited stood out in my mind. Mr Seng was a 49-year-old software programmer married with a wife and young son. Two years ago, he suffered a massive posterior circulation stroke complicated by secondary hemorrhage. His stroke had left him a functional quadriplegic; his jaw was also paralysed, leaving him unable to open his mouth to eat or speak, necessitating the use of nasal gastric tube feeding. Moreover, after his stroke, Mr Seng had spent much of his life shuttling in and out of hospitals, suffering from recurrent chest infections due to near constant aspiration – a consequence of the

neurological damage to his swallowing reflexes. Painful bedsores had begun to form due to prolonged rest in bed, and with each longer visit to the hospital, Mr Seng was at risk of catching even more serious infections.

Dr Lavender remembered that when she first saw Mr Seng as a new referral, he was crying. He and his family had been told repeatedly by many doctors that his future rehabilitation potential was poor, given the time elapsed since the stroke; moreover, surgeons could think of no solution for his paralysed jaw. For such a young professional with a family, his stroke had changed his life forever, and he had to deal with the grim prospect of being dependent on others to feed and move him.

After carrying out an assessment, Dr Lavender had disagreed with these prior opinions about his prognosis. Though Mr Seng was young in the eyes of medicine, geriatric care principles that focused on assessment and attainment of functional goals were still applicable. As a patient who had been formerly healthy, Dr Lavender believed that he deserved another chance. Under her guidance and the care of the PACH team, Mr Seng underwent a series of intensive physiotherapy sessions. When Mr Seng's nine-year-old son became involved in helping exercise his paralysed body, he drew motivation from the love of his boy and family to give his all to complete the slow and demanding course of rehabilitation.

Behind the scenes, the team had advocated and secured funding for walking aids custom built and flown in from the USA because of his height – I could see several of these wheeled frames in the living room. In addition, the team consulted many medical colleagues in other hospitals and specialties on interventions for his paralysed jaw muscles and to develop visual aids to help him communicate with family and caregivers. Over the next few months, Mr Seng regained the ability to move his arms, and walk assisted by devices. He could now physically interact with his son, and even sit at the dinner table with his family – something his mother said she thought she would never see him do again.

When I met Mr Seng in his home that afternoon, he was resting in his bed and being tended to by his mother. After Dr Lavender introduced me, she proceeded to examine him. I couldn't help but notice how the family took to Dr Lavender and Nurse Cheng like old friends. The way Mr Seng responded with his eyes and hand gestures to questions, the way they made shared care decisions, to the way the pride collected in Dr Lavender's voice as she recounted how far he had come despite the odds – which all spoke to the strength of the patient-physician relationship. Dr Lavender explained that Mr Seng's next goal was to regain the function in his fingers, after which it would be possible to access funding for a mobile scooter and computers operable with joysticks.

As he grows stronger, I cannot help but think of how different Mr Seng's outlook now is. Although he will not regain all the physical ability he has lost, he has regained the ability to participate in life and the lives of his loved ones. Soon, Mr Seng will be discharged from the care of the PACH team, due to the programme limit of three months of follow-up. The community of allied health providers, volunteers, and friends will continue to care for Mr Seng, with the PACH team providing support if required.

## Reflections

It was a privilege to be invited into the homes of patients, and to see and help in the work of these dedicated multidisciplinary teams like Dr Lavender and Nurse Cheng. There are difficulties unique to home care, such as the extensive travel times for providers and difficulties in accessing areas poorly served by transit. Providers need to be more self-reliant, because once "out there", they are relatively isolated from the resources of a hospital. In the words of Dr Lavender, "you only have what you bring with you". There are also the unexpected costs that teams spend out of pocket for patients, such as food and supplies that are often not reimbursed by the hospital. Most of all, they must deal with the uncertainty of what they might face behind each door.

Though clinical frameworks are helpful, there will never be a checklist to capture all the resources, some of which lie latent in the community, that are needed to be marshalled for each patient. But like many other home teams I have met, Dr Lavender and Nurse Cheng shrug off these frustrations as part of the challenge of delivering a more complete form of care: holistic care.

The multidisciplinary community care units encompassing both post-acute care and palliative care across the country are defining what medicine can be for each patient. Returning once more to that image of the doctor poised on her patient's doorstep, I believe they are the modern equivalents of the few who journey through rain or shine, answering calls for help.

## Acknowledgements

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***References***

1. *World Health Organization. Constitution of the World Health Organization. Available at: http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf. Accessed 1 April 2015.*
2. *Gawande A. The cost conundrum. The New Yorker 1 June 2009. Available at: http://www.newyorker.com/magazine/2009/06/01/the-cost-conundrum. Accessed 1 April 2015.*

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