VISITING AND RE-VISITING HOMES

By A/Prof Cheong Pak Yean

Of my various teaching assignments in medical school, my favourite is the Community Medicine Patient Study (CMPS) taught to third-year medical students. This is the learning exercise where in-patients clerked in the medicine posting are followed up for three months. Besides continuing medical care, other psychosocial issues and its impact on health and illness of that patient are studied. The exercise therefore entails visits to the patient's home and interacting with their relatives. CMPS focuses on person-centered medicine.

Accompanying groups of mostly young, enthusiastic doctors-to-be in the home visits for the past decade evoked memories of the two "social medicine" patients I clerked in 1972, one each in my pediatrics and internal medicine posting. During the tutorials preceding the visits, I would proudly pass around the bound folios of these two patients to bring home the point that this exercise has been around in our medical schools for decades, and the assigment was worth doing well. I would draw attention to the medieval tools I used to produce the two reports. Then, the reports were typed using the mechanical type-writer, one stroke per letter directly onto paper. If a typing mistake was made, I had to rub the imprint off with an ink eraser – carefully, without making a hole through the paper! Diagrams and home plans were drawn by hand. The photos were all taken using analog cameras and then physically pasted in. The physical evidences of my work never fail to trigger waves of "wow" and I suspect also relief that their tasks in producing the reports are now so much easier with personal computers.

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Somehow in all these ten years, I never made time to read the two reports cover to cover until last week, when I had half an hour between the end of a tutorial and the rendezvous with another group of students for a home visit. It then struck me that though the stories of my two patients are different now as Singapore has progressed into a developed nation, there are common lessons of life. Salient visits in the past years came to mind and I revisited the joy of learning medicine.

HOMES OF OLD

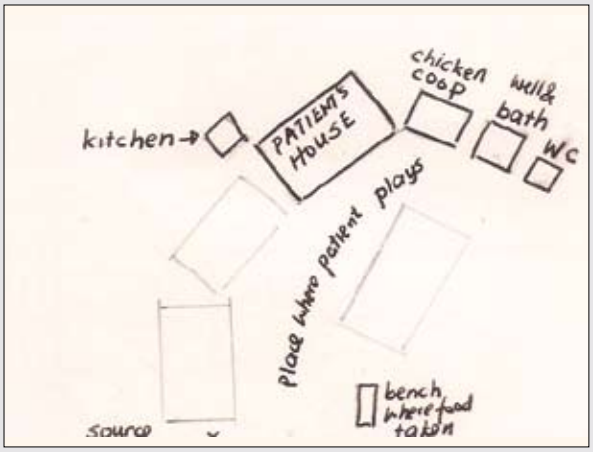
The four-year-old Malay boy was admitted for anaemia of 4.7 gm% due to infestation with round worms, hookworms and Entamoeba infection. The sketch that I made of the house and its vicinity during the home visit revealed the causes (Figure 1) – the bucket system latrine, shallow well, the chicken coop, the kitchen and the open air dining area were all sited in close proximity. Also, the floor of the entire area was not cemented.

The second patient was a 46-year-old Indian man admitted for cardiac failure and encephalopathy caused by untreated hypertension and alcoholism. He was a manual labourer with a large family of ten children living in a cramped two-room house. I drew a pie diagram documenting how he spent the hours of his days – two of which after work were spent in drunken stupor intoxicated with toddy (indigenous liquor fermented from palm sap) and cheap but potent ''Orang Tua'' chinese wine. He had multiple nutritional deficiencies as well and I remember how he was loaded with bottles of intravenous vitamin cocktails in the wards.

The Malay kampongs in Changi have since made way for concrete skyscrapers. The toddy shops are long gone and so has the factory at Henderson Road making the fermented rice wine with the old bearded man (Orang Tua) trademark on the bottle. The change in the medical students' case-mix mirrors the development of Singapore. I draw the attention of the students to the diseases of "old" Singapore – of poverty and unsanitary environment, large families and illiteracy. It provides epiphaneous teachable moments of medicine beyond books.

Figure 1

Topography of the Malay kampong house circa 1972



BIO-PSYCHOSOCIAL FORMULATION

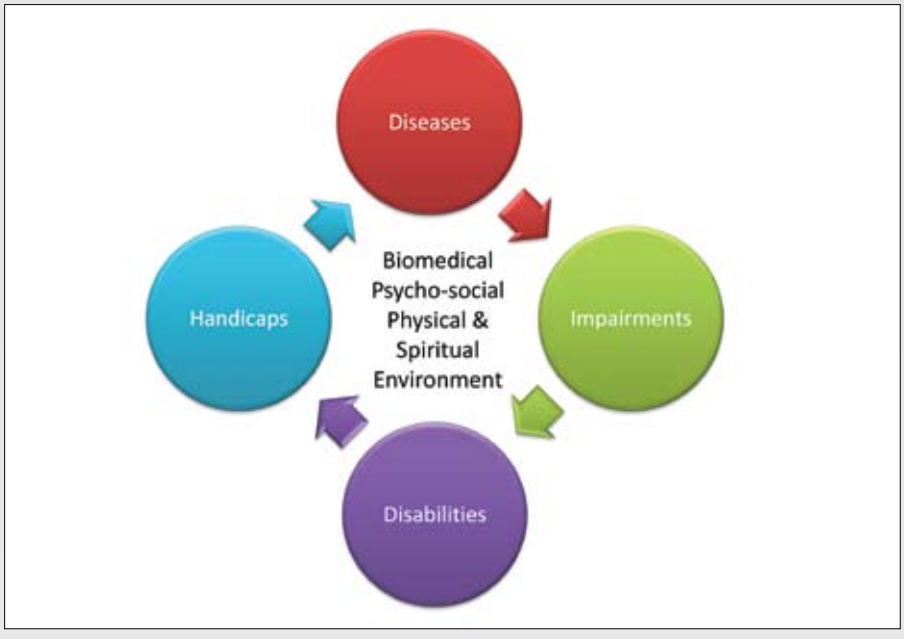
In the CMPS programme, I teach medical students a mantra (see Figure 2) that exhorts them to look beyond the disease labels of patients – beyond our tidy way of putting patients with shared clinical characteristics normatively in labeled groups. In life outside hospitals, these diseases impair functions and create disabilities. The bio-psychosocial-physical environment may exacerbate or ameloriate these disabilities thus producing handicaps.

I counsel the drawing of family genograms and the parallel charting of a psychosocial timeline juxtaposed with medical events. A formulation of the issues can then be made for a total management plan.

Today, the patients clerked by the medical students posted to the class "C" wards of public hospitals are still from the lower socio-economic stratum of Singapore's society. Our visits take us to HDB flats usually of the one or two-room variety. Medical students learn to appreciate the differences that family and friends can make to alleviate the ravage and suffering caused by diseases and disabilities. Welcome to the real world – not just of caring in hospitals with high technology but in the community with high touch.

Figure 2

Patient Centred Approach to Management



VISITING LESSONS OF LIFE

Lesson: Medicine No Enough

I remember the 40-year-old wage-earner with a homemaker wife and young child who had embolic right hemipareses secondary to atrial fibrillation triggered by uncontrolled thyrotoxicosis. He quit taking his carbimazole for preceding months as attending a polyclinic for his anti-thyroid pills meant an ill-afforded half-day off work. One night, he developed right-sided weakness that landed him in hospital.

In the home visit after discharge, I asked the medical students to check his follow-up appointments and to our astonishment, we found that he had five appointments all on separate dates – one each for neurology, cardiology, endocrinology specialist out-patient clinics and two others for speech therapy and physiotherapy. There were multiple packets of medicine prescribed by each clinic and the students found discrepancies between the amount dispensed and the appointments. Luckily for the gentleman, the students were able to do some co-ordinative work. This was indeed a lesson for the students about the dires of fragmented care in specialised services delivered from hospitals.

Lesson: How to 'con-plank'?

Then there are home-bound patients who are needlessly admitted to hospitals. There was a bed-bound patient who was frequently admitted to hospital, the last for food poisoning. We found during the visit that there were two GP clinics at the ground floor of his HDB block. Apparently, the patient never saw these two private doctors and the ambulance was called whenever he was ill.

The husband of another patient with below-knee-amputation even asked me how he could expediently 'con-plank' against the ambulance nurse who recently refused to take his wife to hospital after a triage at home. The husband wanted to know the direct telephone line in the Ministry of Health to call, so as to override the nurse's decision. He grumbled that he would otherwise have to queue to complain to his member of parliament in a "meet-the-people" session. "Right-siting" of patients is not just a medical problem.

Welcome to the real world – not just of caring in hospitals with high technology but in the community with high touch.

Lesson: A mother's love

We visited a diabetic man with below knee amputation (BKA) living with his wife in a three-room flat. The home was an urban slum and the living room was stacked high with old discards. In the kitchen, the patient was using a sharp object to pry open the covers of aluminum cans before flattening them with a hammer even though he was just discharged after BKA for diabetic gangrene. The story emerged that in the wee hours of the morning, this elderly couple rummages through dustbins at bus-stops and coffee shops in the vicinity for discarded cans and then processes them to sell for a few cents each. The public assistance allowance they get was just not enough to pay for the upkeep of their family.

The reason for their desperation in making ends meet came from one of the two bedrooms. To our surprise, the room was where the couple's two grown up sons were kept contained; two severely mentally retarded young men sans clothes. The wife hastened to explain that keeping them that way was the only solution as they soiled themselves very often and would sometimes tear and even eat their clothes. I asked if she would like us to get the boys into homes for the disabled. She said philosophically, "no, not yet" as she was still able to care for them. Many years ago, an older retarded child of hers died in a custodian home a few months after admission. We felt very sad at the misfortune of this couple and were humbled by their quiet stoic dignified response to life travails.

Lesson: The 'loving' wife-carer

Routinely, medical students are taught to identify the carer of patients on discharge. A 58-year-old-man, in good health prior to a sudden right-sided stroke told the medical student that he had a loving wife who would take care of all his needs on discharge. However, when we visited him at home, we did not see anyone else. We noticed that awards for community service hung on the walls. Photos of him in his younger days taken with his Member of Parliament were also prominently displayed. He was a successful man, a community leader in his prime. However, we did not see any family portrait, no social memento. Just as we wanted to ask his permission to have a look at the apartment, a bedroom door suddenly sprang open and we saw a small boy darting out. Just as abruptly, we heard a female shouting at the boy in a foreign tongue. In a jiffy, we saw a hand snatching the boy's shirt to drag him back into the room, followed by the slamming of the door.

Then there was silence. We cut short our visit. Later the student found out from the social worker that the man had divorced his wife and left his family after withdrawing his CPF cash bonanza

at 55-years-old to marry a young Thai woman. The student later wrote in his report that the supposedly loving wife-carer, son in tow, went back to Thailand a month after the patient's infirmity.

Lesson: 50-cent lunch & free company

We also visit community outreach centers near patients' homes. Recently, we visited a day activity centre in at a HDB void deck that elderly residents can come in for the day for social activities and a subsidised 50-cent lunch. The centre manager also explained to us how it facilitates other social services provided by volunteers. Emergency cords that trigger audible distress alarm are also installed in some of the rental one-room apartments. On activation, light panels at the lift well and the centre would identify the units with residents in distress.

These medical students now understand that keeping the population healthy is not just by doing the "quick" high end stuff in hospitals, but also slow medicine in the community. Healthcare is more than just good doctoring.

Lesson: Lethal injections

Our home visits are usually made when the patient is discharged. We are thus able then to see the patient in his or her own environs. One Indian lady in her mid-thirties was an exception.

She was admitted for another episode of infective endocarditis and hence had to remain in hospital for prolonged periods for antibiotic injections. Her tricuspid valves were damaged when she illicitly injected crushed subutex tablets meant for oral consumption into her veins. Three years ago, subutex tablets legally prescribed by some doctors as misguided substitution therapy for heroin addicts became cheap fixes when used in intra-venous injections. This dangerous practice caused disseminated infections all over the body leading to damaged hearts and amputated limbs.

Our patient who had gotten married as a teenager was soon abandoned by her husband after three children. Her present husband was now in jail for drug addiction. Even though she was still hospitalised, we made a home visit to learn how the three kids were coping. Biomedical, psychological and social problems are enmeshed in this patient to perpetuate the escalating inter-generational destructive spiral.

REVISITING THE HOME OF MEDICINE

During the home visits, the students would introduce me to their patients and relatives. And sitting around the patient at his/her home, I would facilitate the patient to narrate the story – from the piquant to the mundane from medical events to salient social milestones. Medical students would often be surprised at how much more interesting information we get just by actively listening to patients in the familiarity of their homes rather than the antiseptic ambience of the hospital. Besides pointing out the physical habitat viz. hand-bars, toilets and so on to assess activities of daily living (ADL) and independent ADL, we learn about the patient and his family by just looking around. Pictures on the wall, collectibles, and religious paraphernalia all add up to the making of the man.

Certainly, the cases described above stood out because of their poignancy but they are thankfully not the norm. The students saw heart-warming cases of a whole family gelling together to meet the medical needs of a man who needed peritoneal dialysis, of a family member stopping work to tend to another at home. Reforms to our healthcare system have also addressed some of the disjuncture. The PCPS (Primary Care Partnership Scheme) now subsidises the fees of the poor when they visit GPs. There is now a maid levy subsidy given for house-hold with an ADL-dependent member.

Akob, the four-year old Malay boy I clerked in 1972 is now 41 years of age and probably in good health given our high standard of medical care. But he is epitomised by more than the fading typed words on print. Akob remains frozen in time in my mind as the little bare-footed boy happily playing "chatek" with his friends in the courtyard when my clinical group visited his home together with our supervisor Dr Ivan Polunin. Lean kampong chickens were seen scurrying around and ferreting the helminthes-infested soil for earthworms. The aromatic fragrance of freshly cooked curry from the kitchen and the putrid stench of ammonia from the bucket latrine alternately assuaged and assailed our nostrils as we inspected the compound. The friendly greetings by the Malay family still ring in my ears.

These pleasant memories are etched in the attics of my mind, giving substance and depth to my study of Medicine. I hope that the students whom I supervised for the Community Medicine Patient Study (CMPS) programme each have the same enriching experience. I believe the CMPS has opened up the vista of generations of Singapore trained doctors to what the practice and calling of Medicine should be all about. SMA

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