'This was a model of what good home care could be when the patients can afford it', I thought to myself. I proudly brought medical students and family medicine trainees along on my visits.

THEN THE OLD MAN DIED.

Our ingress into this world was naked and bare.
Our progress in this world is trouble and care.
Our egress from this world will be nobody knows where.

D. H. Lawrence

'Let it not be pneumonia'. That thought reverberated through my mind after I received a phone call from the son of the old man one Sunday night. 'My father was found dead. Could you come over to give us the death certificate?' he said in a matter of fact tone. Death was not unexpected from a 80-year-old man, bed-bound for three years after a massive stroke left him aphasic and hemiplegic. But 'let it not be pneumonia', I thought. That would be ignominious after all the high drama three years ago when he spent weeks in intensive care and the home care that was lavished on him through the years.

The Old Man

The old man, the patriarch of a well-to-do family had a dense dominant hemisphere stroke three years ago and was admitted in a coma to the ICU of a private hospital. After weeks in the ICU on respirator, he contacted MRSA pneumonia on top of the lungs racked by too many cigarettes. He was brought back from the brink of death by the marvels of 'hi-tech' medicine.

He was discharged home speechless, bed-bound and a shadow of the man he once was. The family wasted no time in organising the house around him. They had no lack of medical advice. A grand-daughter is a doctor and so are many close family friends. The living room was re-modelled in the fashion of a ward and so was the adjoining toilet and bathroom. A fully automated bed was purchased and so were nursing paraphernalia. Three maids were deployed to provide care round the clock.

I was asked to provide home visits – as part of a team of sinseh, acupuncturist, and physiotherapist assembled by the family. 'Could you see my father once a week and preferably on this day?' was the request. I was reluctant to take up the responsibility amidst my heavy out-patient load and the many public functions that I need to attend. I also had misgivings about being held responsible for the concurrent treatment given. I understood the pressures the family was undergoing whenever someone proffered a cure. I took the challenge and kept a close watch on the patient. I played for time.

In the initial months after discharge from hospital, there was no lack of persons predicting that the old man could walk again. Waves of enthusiasm and hope would herald the start of yet another would-be miracle cure. A visiting 'professor' from China gave daily injections of herbal extracts in addition to numerous capsules. This was at the time when there was intense interest in TCM in the media. After thousands of dollars, the right side remained motionless. The family began to accept the old man as he was. I began to take over the total home management of the patient.

The Family

It was not just the care of the old man. The conflicts of the family members over the once proud patriarch threatened to compromise my professional duties. The old man was once 'hijacked' to undergo out-patient physiotherapy in a hospital by one of the daughters despite the protestation of the wife who felt that he was too frail to be moved around. 'What do you think?' the daughter asked, 'Is structured physiotherapy at the hospital good for my dad?'. Obviously, there was drama behind the scene. As a physician, I do not want to be caught in the cross-fire of differing opinions amongst the relatives.

'Pneumonia' intervened.. The old man developed a nasty chest infection a few days after the hospital out-patient visit. Treating the pneumonia at home was not a problem. Physiotherapy at the hospital was obviously out of the question then. The need for total management of a patient in the context of the family was not just an aphorism dished out to younger doctors.

The old man had the usual episodes expected of a bed-bound frail hemiplegic patient with diabetes, hypertension and a bad chest – occasional bed-sores, bladder infection, oral thrush. These were all treated in good time. For three years, he was managed at home with the exception of an episode when he had generalised convulsions and was admitted for CT head scan and observation. The weekly home visit was soon changed to a two weekly routine when his condition stabilised.

'This was a model of what good home care could be when patients can afford it', I thought to myself. I proudly brought medical students and family medicine trainees along on my visits. 'This sit-down toilet is specially constructed to be the same height as the wheelchair to permit easy transfer', 'The old man is nursed in a corner of the sitting room where grand-children played and where family life revolved around'. This was a good case for instruction for young doctors and doctors-to-be.

Last Call

In my last home visit a week before the old man died, there was nothing unusual. The old man was sleeping too much and the day-time anti-depression drug was reduced. The ripple bed that was sent for repair was now working well and the bedsores that were developing seemed to be healing. His teeth however were still in a sorry state. The family dentist that was asked to attend to him was reluctant to extract the decayed teeth in the house. I telephoned the chest physician that took care of the old man in hospital. He agreed to arrange an admission so that dental clearance can be done in theatre under anaesthesia. A few days passed.

The first thoughts that raced through my mind when I received the call from the old man's

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son on Sunday night was that the old man could have aspirated those nasty germs in the mouth and had died of aspiration pneumonia. 'Would the family think that I am tardy as I have explained the need for admission to hospital for dental clearance?' 'Who would the family blame, the maids and the mother for not raising the alarm early?' 'Would he have died anyway in hospital if he were admitted for dental treatment?' 'Surely in the age of miraculous antibiotics, one should not die from pneumonia'. I drove to my clinic to collect the death certificate book. I was troubled as to what I should write as the cause of death. It was almost midnight. However, Goh Lee Gan must still be awake.

Rite of Passage

We discussed. The probable causes of death could be pneumonia, myocardial infarct or cerebral thrombosis. Giving "pneumonia" as the cause of death here may open up wounds in the family and fingers may be pointed to the direct care-givers. It was also a let-down for medicine after so many battles against the bugs were fought and won. It was however clinically the most logical diagnosis. 'Make sure the due process of consultation is carried out. Speak to the relatives before writing the death certificate. Complete the healing process'.

There was silence when I arrived at the house. I confirmed death and then began my conversations with the relatives before I issued the death certificate. There was nothing unusual when the extended family gathered for their Sunday dinner. 'I fed dad and he could swallow feebly as usual and he was dozing off when I left at 10 p.m.', a daughter said. 'No, he did not have fever, no cough, looks OK', the maids chorused. 'Should we have called you earlier' the mother wanted to know amidst the gaze of the family, 'Would he be alive if he were admitted to hospital as you have suggested for dental treatment?'.

After the elders had spoken, the ten year-old grand-daughter who raised the alarm interjected. 'I was playing around grandpa's bed when the left side of his body shook for a few minutes before he became still'.

The healing process was complete. The family was at peace. Then the old man died. ■

'Our egress from this world will he nobody knows where'.

Cheong Pak Yean