Calvary Hospital (Eastchester, Bronx)

Calvary Hospital is the affiliated hospice care center that TCC is closely in contact with. We were well fed and greeted by the attending physician at Calvary Hospital, Dr. GC. Along with ten SUNY Downstate fourth year medical school students, we were given a lecture on the common conflicts that spring up in nursing homes such as Calvary. In addition, Dr. GC herself graciously took us on a tour of the third floor. There, we were able to visit four different residents, with four different background stories.

Most memorable of all was a 95-year-old lady, weighing no more than 70 pounds, who is afflicted with end stage dementia. She has four children who each telephone the hospice care center daily. Dr. GC jokes that these four phone calls have become the highlight of her day. We hovered outside the room of this lady and saw a frail, comatose individual. Just two weeks ago, this 95-year-old lady was mowing her lawn. Unfortunately, she took a heavy fall and the shock altered her mental status. Her children expected her to become ambulatory again in a week. However, when an elderly takes a fall, it is very unlike when young ones fall. Hip fractures have proven to be a significant cause of death in the elderly post-fall. Here, we witnessed some discrepancy between the family’s expectations and perceptions and reality.
Our Calvary Hospital visit tied together in the end with a few more meaningful comments from Dr. GC. She voiced many of the same concerns that TCC face on a daily basis.
Mr. S was discharged today. At the sub-acute morning report meeting, this news brought a round of applause and cheering. This 70-year-old Korean man was born and raised in Japan. He attended a University in Korea and obtained his Chemical Engineering degree there. He later immigrated to the United States to pursue his dreams. Aside from fluency in Japanese, Korean, and English, Mr. S is also a master of the German language. From his Tae Kwon Do black belt to his time in the U.S. army, this man seems to have an endless abundance of stories to tell. Currently, Mr. S resides in a 10-floored senior citizen apartment. His family members are all scattered across the globe and have difficulty in coming to his aid. Instead, he relies much the help of his two best friends, whom we have fortunately met once. They live in the adjacent floors of their senior housing.

Subsequent to a cranial surgery, Mr. S recovered gradually and successfully. He is fully ambulatory, and his mental status is significantly better compared to the days immediately post his surgery. It became a daily sight to see Mr. S hovering about the fourth floor nurse’s station. He loves caffeine. When we visit, if he were not already drinking a cup of coffee, he would kindly ask us to get him some. We are glad that he is finally going back to his home.

We find, sitting inside a small single room, Mr. F resting on his chair, with neck bent and head completely down. His left hand clutched tightly to the walker. This 68-year-old man used to work as a housekeeper in this institution, before it became a nursing home, for some thirty years. He has recently been placed on hospice care and is eating very poorly. Upon our entrance, Mr. F attempts to tilt his head upward to glance at us. He nodded appreciatively when we introduced ourselves as summer interns for TCC. After a bit of small talk, we can sense his great independence and dexterous thinking through his clear, loud voice and careful word choice. At the same time, he emanated lament and disappointment through his unsatisfied looks at the breakfast plate.

“I’m a baby.” Mr. F joked when we asked about his age.

Mr. F had made several complaints of excruciating pain in his chest area. Dr. L entered. They conversed about a possible tour of the building, providing Mr. F a chance to see what changes have been done to the facility. His spirits lightened, and we were glad to leave on a cheerful note.

Follow-up note: On August 4, Mr. F’s situation worsened and he was transferred to Calvary Hospital. Over the past month, his mental state deteriorated. He had hallucinated that his wife was being beaten up. After all, he no longer sees her on a daily basis. His appetite grew poorer still. He became violent with the nurse’s aides because he is doubtful of their
intentions. On August 1, Dr. L gathered together all the physicians, social workers, and directors and conducted a case study conference on Mr. F. Dr. L pinpointed where TCC staff could have performed better and which areas we did not touch upon. For now, we hope the transfer and relocation to Calvary was smooth and comfortable and that he is becoming adjusted to life there.
Ms. SP (initials changed) originally arrived at TCC as a sub-acute patient. Unfortunately, her medical conditions worsened over time, and now she transferred from rehabilitation to a long-term care floor. At age 48, Ms. SP has already experienced two stroke episodes.

Before arriving in front of her room, we can already hear the labored breathing and gurgling of the throat. There was a large amount of fluid accumulated in her body, and she was not eating very much. We had the pleasure of meeting her daughter, R, and her eldest sister, B. B recounted when Ms. SP was diagnosed with cancer ten years ago. Ten years later, the cancer sprouted back with full force. Within the short span of a week, Ms. J's health deteriorated dramatically. She is now bedridden, unable to take in food. For most of the times we visited, her eyes are close, and we find her in a comatose state.

It was not always this way. Her sister reminisced. Coming from a family of nine children, Ms. SP has always been feisty and headstrong, with a good heart. She loved the New York Post newspaper and enjoyed being able to move around in her wheelchair. Slowly, her poor health deterred her from doing the things and being with the people she love. B was having an especially difficult time adjusting her own feelings about the situation.

“I don’t want to be here when she stops breathing. I just can’t be here when that happens.” B said, full of indescribable sorrow. Their mother was not handling the situation very well either, and the brothers in the family have all broken down. It was left to the sisters to pick up the job of visiting Ms. SP, caring for and supporting her. B spoke to us in a slow and calm tone; we can see that she was sad about but accepting of the situation. The
housekeeper came in to clean up a spill on the floor. She cracked a few jokes, and the atmosphere softened.

Dr. L’s prognosis of Ms. SP is not promising. She is expected to not last the weekend. Vaginal carcinoma, lack of food intake, and comatose state together accumulate in an unfavorable outlook for her. We cross our fingers as we await the long weekend ahead.

Follow-up note: Ms. SP passed away five days later.
The care plan meeting of Ms. SP involved a conversation with her husband, who was admitted into TCC nursing home only a few months after his wife. Ms. SP has always been a poor eater, according to her husband. On a good day, with constant cajoling and encouragement from Mr. SP, she will intake a few bites. Even so, she eats very slowly and can become easily agitated if rushed. Just a few weeks ago, due to his intense worry and concern over his wife’s declining health, Mr. SP experienced an episode of heart palpitations. Yet, during the care plan meeting, he specifically requested one of his exams to be delayed so he can stay by his wife’s side until she improves.

Today, we observed the conversation between Dr. L and Mr. SP. The goal of the care plan meeting was to establish the viability of percutaneous endoscopic gastrostomy (PEG), or tube feeding. In addition, because Ms. SP is experiencing dementia and may not be making sound judgments, it is important to get the husband’s take on the issue from his experience of living with her. Due to the difficulty of gauging what Ms. SP wanted for her end-of-life care, this meeting became especially significant. She has been developing a rather large wound on her back, due to long-term stay in the bed without moving. If her malnutrition and refusal to eat persists, the wound will exacerbate and likely become fatal.

As the conversation with Mr. SP unravels, we receive a much better sense of her situation: “She does not mean to die at all”, “she is not afraid of death, but she has no intentions of committing suicide”, “I will make her take her food if she has to”, and “she is extremely afraid of doctors and does not understand what tube feeding is”. Listening to his words made us realize how much he cares for his wife, but more importantly, she is in it to live.
Mr. SP also expresses the wish for tube feeding to be the absolute last resort. His information that she is willing to eat breakfast is very crucial and helpful. The dietician will now try everything possible to boost the calories and nutrition in her breakfast, to make her stronger and fight the worsening wound. Near the closing of the meeting, the nurse practitioner carefully explained to Mr. SP the meaning and details of a Do Not Resuscitate (DNR) order. After some consideration, the husband signed the form.

Later, in the resident’s room, we met Ms. SP. She did not say much and was not interested in hearing Dr. L’s jokes, but she did agree to try harder to eat more and sustain herself. Looking at Mr. SP, she says: “He’s the best husband in the whole world.”

Follow-up note: Today is August 8, 2011. The intubation process of Ms. SP’s PEG tube had been successful. She is now officially being fed through the tube, with a side of food that she can take in per oral. However, during both the morning reports and lightning rounds, Ms. and Mr. SP’s case has been repeatedly brought up. Mr. SP is growing ever more so impatient with the staff and aides because he believes they are not providing adequate care for his wife. Meanwhile, Ms. SP’s appetite remains poor. Despite an intake of sufficient nutrients, her leg and back wounds are refusing to go away. Physicians and nurses alike are concerned about Ms. SP’s condition. The best we can do, as of now, is hope for the best.
Let the Lessons Begin by Huili Zhu, June 21, 2011

Time: 3:20PM

Note: The stories we will recount are true. In order to protect people’s confidentiality, we changed the names of the patients, their families, nurses, and physicians.

As interns for the CSSR program at Terence Cardinal Cooke this summer, we had the privileged chance of observing a palliative care meeting between Dr. L, the chief medical director, and the Rosario family. Ms. Annabel Rosario, as we will call her, is a frail, 91-year-old, 80-pound lady who is facing inevitable decline. Each day, sadly, brings her one step closer to death. Her two daughters, Emily and Sarah, sat with Dr. L yesterday afternoon to discuss mother’s situation. Emily Rosario had been a former resident here at TCC nursing home, and now, she is back as her mother’s health care proxy. Emily wholeheartedly works with the nursing home staff, in hopes of bringing mother as much comfort as possible. Sarah, however, has shown a history of causing problems for the staff, being belligerent, and having unrealistic requests toward her mother's care.

“At a nursing home,” Dr. L says, “the goal is for everyone to die peacefully and comfortably.” There is no way we can eliminate all the pain, but we can try our best to provide care and solace for the residents as they are nearing the end of life.

Yet, Sarah insists on mother’s transfer to a hospital. At nursing homes, hospital transfers are avoided as often as possible. At a certain age and health situation, a resident will likely be harmed much more than be benefited by going to an acute hospital. For example, performing CPR on an elderly, debilitated person has a high chance of failed revival and will likely cause irreversible fracture of the rib cage. The main goal of an acute hospital’s
emergency room is to rush patients in and out as quickly as possible. A hypothetical situation in which mother Rosario is sent to a hospital will likely entail intubation, violent technological tests being performed, and a great deal of discomfort. Sarah does not seem to understand that. She lacks the trust that builds the foundation of a doctor-resident-family relationship.

After an hour of patient explanation, Dr. L was able to persuade Emily into signing the DNR (“do not resuscitate”) form. This will hopefully help the family understand the details of advanced directive and bring mother Rosario’s care one step closer to TCC’s goal. Palliative care remains a difficult subject for families to consider and discuss. This is no surprise, as no one enjoys the thought of preparing for a loved one’s death. Nevertheless, it is a crucial step in reducing the pain and suffering of each individual who is facing the end of life. Consider a person who has lived in the nursing home for five or even 10 years: He or she is likely to consider this place home. For this resident to pass away peacefully, with hands held by family members, in this home, is infinitely more desirable than in a hospital, with tubes and needles puncturing throughout the body.

“We have to learn to let go,” Dr. L reflects, “It is a natural process.”

Indeed, we have to learn to accept this natural process, despite the harshness and difficulties. Walking up to the ninth floor administration offices, we come across Nurse G. who expands our perspective. Looking at the whole picture, she summarizes: “If there are 100 families in this nursing home, there are at least 101 dynamics.”

True. This is precisely what makes care plan meetings and doctor-family interactions a challenging task. People are different. There are reasonable and understanding families,
but there are also dysfunctional and disillusioned families. On the road to learning and hopefully perfecting palliative care, we have much more to learn.

Follow-up note: On June 23, Ms. Rosario passed away. Thankfully, she passed in relative peace and comfort, without violent resuscitation procedures.
Following Footsteps by Huili Zhu, August 9, 2011

During Summer of 2011, CSSR interns Huili Zhu and Ashley Shaw, undergraduates at Columbia Engineering ‘12 and Columbia College’13, respectively, will be following Raphy Rosen’s footsteps. They will devote time, thought, and new ideas to palliative care research at Terence Cardinal Cooke Health Care Center.

The pass-off was smooth. Raphy had kindly walked the two interns through background knowledge of TCC and explained his own project to them in detail. Through his eyes, Huili and Ashley grasped an introductory sense of the summer ahead: learning about the unknown field of palliative care, finding comfortable and useful roles at TCC, and most importantly, interacting with physicians, social workers, residents, and family members.

One step at a time, Huili and Ashley will carry new ideas and venture forward on the path to understanding and improving palliative care.