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VIEWS AND REVIEWS

CRITICAL THINKING

Matt Morgan: Hospital doctors should step outside

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Last year I did something I found difficult, unsettling, and risky. Yet, in many ways, it was a simple act that community health workers do every day. It didn't involve a complex procedure or a new treatment. I even wore a pair of jeans while I did it.

Last year I stepped into the home of a patient I'd cared for while he was critically ill many years before. I left the safe neon confines of "my" hospital and entered "his" softly lit world of home. I was the visitor, the guest in his life rather than he in mine. That experience changed me. It was a powerful way to navigate the fog of medicine that surrounds us in hospitals.

Until then, my "patient follow-up" had involved seeing an empty bed in the intensive care unit. This meant that the patient had either died or got better. Occasionally I'd expand this window further, by visiting people on the ward after leaving intensive care or by looking at their date of discharge on the hospital computer. To my colleagues, a "did not attend" at an outpatient clinic may represent something similar: the patient didn't come, presumably having got better or perhaps worse.

This binary view of the future is, of course, not real life. While survival is good, it's not always good enough, and we should strive towards what's important to patients. What better way to frame these hopes than to see patients living their own life? Before I saw the other side of that journey I was ill prepared to advise on what route to take. This form of follow-up may be a rare concept in hospital medicine, but it's one we need to learn about from our community colleagues, who have known this for decades.

As I stood in that person's home—seeing the adapted shower, hearing the children playing in the garden, smelling the home cooked food—I was reminded of what medicine's really about. Not a ward discharge, not a hospital discharge, but life returning.

I've come to think of this as "deep follow-up," and I believe that it may help combat nihilism when treating conditions such as traumatic brain injury or cardiac arrest. I later visited a family where life could not return, where the patient had died. But this, too, may give us the humanity to have difficult conversations about survivorship earlier and may help shared decision making about life sustaining treatments.

Of course, this kind of follow-up needs to be done safely, with support for all parties. It may not be suitable for all patients, all families, or all staff. It isn't practical for every encounter. But perhaps we can occasionally flip the narrative and, instead of patients booking an outpatient appointment with us, book a walk in the park with them.

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Patient consent obtained.

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