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ESSAY/PERSONAL REFLECTIONS

The Surrogate Daughter

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In June 2014, 218,300 foreign domestic workers were reported to be living in Singapore (Singapore Ministry of Manpower Statistics, 2014). Many of them, desperately poor, come from neighboring countries such as Indonesia or the Philippines to work. This income enables them to put their young children or siblings through school, buy land for their families back home and also pay off family debts. Due to the relatively meagre salaries of these workers, one in every five households within Singapore currently employs a foreign domestic worker. This allows the Singaporean employer to work full-time, while the foreign domestic worker looks after dependents and loved ones at home.

I first met B on a sunny afternoon. My nurse N and I had just arrived at the ground floor of a public housing estate in central Singapore when N received a call from B. “Ma’am, are you here yet?” came a soft voice over N’s mobile phone. B’s words were hurried. “Please come quickly, Ah Ma is coughing badly,” B said. “Not to worry,” N replied briskly. “We are on our way up to your apartment.” As we hurried up to the third floor, we met B, who was already waiting anxiously for us at the door.

B was a stout middle-aged Indonesian lady with big hands and a soft voice. Her hair was short and frizzled, her clothes slightly crumpled. She had lived with this Chinese family in Singapore for the last two years, employed as their full-time domestic helper. Her primary role, it seemed, was to be the main caregiver of an elderly couple — Ah Ma and Ah Gong (local dialect for grandmother and grandfather respectively).

Ah Ma was the patient we were visiting that day. She was 79 years old, and had been diagnosed with advanced rectal cancer a year ago. Unfortunately she had also suffered from multiple strokes, which left her bedbound and verbally uncommunicative.

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As I hurried into Ah Ma’s room, which was in the corner of her small two bedroom apartment, I heard the on-going “*wrrr*” sound of a nebulization machine. The room smelt of a strange mix of disinfectant and medicated oil. Ah Ma was dressed in an oversized flowery blouse and large sized diapers. She appeared tired and did not open her eyes, even after I called her name. As she coughed weakly, my eyes were drawn to her naso-gastric tube, which protruded out of her nose. Her skin was dry and she had multiple scattered bruises on the dorsum of both hands, some with a yellowish hue. They must hurt. I thought to myself. The referring notes from the hospital team mentioned that they had treated her for pneumonia two weeks ago.

As my nurse and I proceeded to assess Ah Ma’s condition, B hovered in the background looking visibly nervous. “Ah Gong died just after I walked out of his room,” she said abruptly. She had tears in her eyes.

As B shared her story, we learnt that B’s other charge, Ah Gong, had died suddenly in his sleep a year ago. “He was okay just before I left, Ma’am. Why did he die? How could he die, just like that?!”

As I listened to B, I could not help but feel as if I were listening to a woman describe the guilt and trauma of caring for and losing members of her own family. It was the unavoidable emotional devastation which plagues a primary caregiver when their charge dies, or is in the process of dying. What a terrible burden of responsibility! And this woman was bearing it with all her might for a family which was not her own.

It seemed that there was another dimension to her emotional turmoil: as an employee ostensibly hired to look after the elderly folk at home, B was afraid of what would happen if Ah Ma were to die. Would she be blamed by her employers for Ah Ma’s death? Would she be out of a job? Where could she go? Many of her own family members back home in Indonesia were depending on her income for sustenance.

Ah Ma’s family, however, appeared oblivious to B’s inner struggles. They were pleased with B’s performance, and trusted her implicitly to care for Ah Ma

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at home. After all, B had been working as a nurse in Indonesia before coming to Singapore.

"Oh, we definitely treat her as one of us." Ah Ma's daughter said smilingly as she walked into the room. She had managed to request for an hour off from work, just so she could meet N and I. "I think she's doing a great job with my mum," as she draped an arm reassuringly over B's shoulder.

Ah Ma's daughter explained to us that the family (herself and five other siblings) were all blue-collar workers, and had to struggle hard with bread and butter issues, which made B's involvement necessary. "There is no choice; we have to leave B in charge of Ah Ma while we're out working. How else can we make a living?"

B was not only Ah Ma's primary caregiver, but also the de facto decision maker on any medical issues which might present themselves. Had B decided that Ah Ma was unwell, the family would have allowed B to decide all options of treatment, including the need for hospitalization if necessary. The reach of her responsibility over this elderly lady was astounding.

We discussed with Ah Ma's daughter and B, that we would prescribe a trial of oral antibiotics and that the plan would be to care for Ah Ma at home, so as to ensure her comfort. We reassured them that we would be back the next day if Ah Ma was still unwell. N and I then decided to leave Ah Ma's house to review our next patient. As I left, I could not help but feel uneasy. Although B was smiling as we left the house, there was a light of uncertainty in her eyes — a flicker perhaps, but I thought it was there . . .

As if to prove me right, N received a call from Ah Ma's daughter while we were in our office early the next morning. "I just wanted to inform you, nurse, that Ah Ma was warded in hospital yesterday." "Oh no!" said N. "What happened?" N was obviously agitated. As I listened to N over the phone, my heart started to sink. A million thoughts ran through my mind. What had happened? Why did Ah Ma get admitted? Why didn't they call us? Could I have done better?

It appeared that B had panicked and brought Ah Ma to the emergency department after an episode of vomiting, barely a few hours after we left the apartment. It was painful for me as I heard the news, for I had failed to keep Ah Ma at home — an arrangement she might have preferred. I felt that Ah Ma's bedbound status meant that she would be prone to multiple infections and that repeated hospital admissions would eventually prove medically futile.

However, B was neither Ah Ma's legal guardian, nor her surrogate decision maker. Was she the appropriate person to make decisions for Ah Ma? How much did B truly understand about Ah Ma's medical condition and her desired treatment? Although we could tell, even from our short encounter, that B had a close relationship with Ah Ma and she genuinely cared for her as a daughter would, could B's practical concerns of needing Ah Ma to remain alive (in order to ensure her own employment) influence her decisions regarding the best place or plan of care for Ah Ma?

It hurt me to think about how Ah Ma might have been coping in hospital, but it was also obvious to me that her family plainly could not afford to be at home with her. From their perspective, having B assist them in this way was the best and only option.

As I reflected upon these issues, I realized that I had no simple answers to these questions. In our society and many other countries where the costs of living are rising and people are less accustomed to dealing with the nitty gritty aspects of physical care of the sick and dying, there is an increasing reliance on foreign domestic workers to help care for our loved ones at home (Swartz, 2014; Tew et al., 2010). It is a trend that is unlikely to change in the near future.

An esteemed palliative physician recently chided our group of residents for neglecting to even ask the name of the domestic helper during a family conference. These incidences remind me of the strong need to recognize and to work harder to engage with our foreign domestic workers. These often overlooked ladies (or, less commonly, men) labor day and night to look after our loved ones at home, while the rest of us fight our battles in the workplace. They come in all shapes and sizes and hold so many of their own life experiences — running the range from joyous and uplifting to bitter and heart wrenchingly tragic. There must be something we can do, something, to improve their care giving experience (Bai et al., 2013).

Perhaps, that "something" — could simply be, to listen. Let us hear their perspectives, on living, dying and suffering. Let us hear their concerns. Let us hear their thoughts. Let us affirm them.

I'm confident then that outcomes could be better for all — patients, families and caregivers and that we **can** finally, create safe "holding environments" for them (Winnicott, 1960) — places where their strong emotions and thoughts can be contained . . .

> "To have our needs met, to love, to be loved, to feel safe in this world and to each know our purpose, is a simple matter of creating those blessings for others."
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> — Bryant McGill, *Voice of Reason*

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