

Intuition

One of the lessons that I have learned in my many years as a Medical Social Worker is that in this line of work, you can never leave your job at the door at the end of the day. After a while, the intuition and skills you hone become a part of your being and you are “on call” all the time. You can try to separate your professional life from your private life, but sometimes they overlap so strongly that it can be difficult. I remember two distinct incidents when this occurred to me.

Grandma was warded again. As I received the news of my grandmother being treated for her age-related medical condition, I was reluctant about having to trudge to another hospital on the weekend after having spent five days working in one.

As I made my way to her ward, which was at the end of a long corridor, I passed a middle-aged man standing next to a ledge, a short distance from the wards. Dressed in hospital pyjamas and hooked up to a drip, he was obviously a patient. What caused questions to race through my mind was the fact that he was smoking, staring out into the open, and deep in thought. My initial reaction was that he had sneaked out of the ward without the nurses knowing. However, the look on his face showed no indication of any fear that the nurses would reprimand him if they found him smoking at the ward lobby.

My social worker’s intuition prompted me that something was not right and I told myself that I should alert the nurses of the nearby ward to check on this man. Before I could do so, I was accosted by my approaching aunt, who inundated me with details about my grandmother. All thoughts about that man vanished from my mind.

Minutes later, there was a commotion... a man had jumped!

My heart sank. I went to the window and tried to get a glimpse of who it was. The sinking feeling hit the pit of my stomach — it was the same man standing by the ledge. I just stood there watching the medical staff rushing him to the emergency department.

I felt that I had failed in not trusting my intuition, which had hinted to me that this man was contemplating suicide. If I had informed the nurses of my concern, I might have averted the suicide.

There was another time when I was counselling a single 80-year-old man. He had experienced several giddy spells and had been admitted to hospital for treatment. Apart from his physical complaints, he was highly anxious. The psychiatrist diagnosed him with depression and he was warded for a further two weeks for treatment.

The patient was anxious about who would take care of him as he lived alone. Prior to his discharge, I contacted the Senior Activity Centre (SAC) situated at his block which readily agreed to assist him. I also made a referral to SAGE (Singapore Action Group of Elders) Counselling Centre which scheduled a home visit the following day. All looked set and he was given a clean bill of health to be discharged. I escorted him home in order to drop by the SAC with the patient to give him some assurance as well.

However throughout the journey home, he seemed to be engrossed in his thoughts. I asked if he felt all right and he said he was fine. I went to his home to help him settle in, and after ensuring everything was in order, I took my leave. He looked absorbed in his own thoughts as he said his goodbyes to me. I asked if he required me to stay or whether he needed anything else. He said he would manage and I left.

There was this nebulous unease that bothered me. When that disquiet persisted, I called a colleague about it. He felt that since

the patient was already linked up to community agencies, what I could do was to call and check on him the next day if I was really worried.

The next morning, I received news that the elderly patient had been found by the police at 5:15pm at the foot of his block. He had jumped. This saddened me, particularly as I had left him at only 4:45pm. It affected me personally as I was probably the last person to have contact with him. What did I miss? What did that look on his face mean? His depression had improved, and help was on its way. Why could he not wait? I was reminded that there are times when a person, especially an elderly one, who feels that there is no one to care for him becomes determined to end his life. Once again, I learned about the need to listen to my gut feeling, even if it means having to escort the patient back to the hospital in a situation like this.

Suicide is the most serious outcome of clinical depression. Two-thirds of those who are clinically depressed have suicidal thoughts or thoughts of dying.

One of the highest risk periods is when patients are recovering from depression. As the patient transits from lethargy, hopelessness and despair to normal mood and existence, mixed states are common and may result in rapid mood swings, perturbations of energy and disrupted sleep. The energy that accompanies the recovery may make the patient find the strength to act out earlier suicide thoughts and plans. It is difficult to distinguish those who are genuinely getting well and those who kill themselves on impulse.

About one-third of hospitalized psychiatric patients “look normal” to their doctors, family members, or friends in the minutes or hours just before suicide. It could be that they have made the decision on suicide and are relieved of the anxiety and pain of having to live their lives.