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Singapore's medical social service began in 1949 at the then-Outram Road General Hospital, now called Singapore General Hospital. The British colonial government started it as they saw the urgent need for welfare services in the post-war years. The first almoner (what a medical social worker was then called) was Ms N Tanburn, an English lady. Her main focus was to provide financial aid to needy patients, to ensure that they had access to nutrition and basic healthcare. Our key healthcare problems then were high infant mortality, poor child health, as well as infectious diseases like tuberculosis and leprosy: problems of a third world.

Over 60 years, as Singapore moved from third-world to first, the medical social service has progressed in response to changing needs. What began as an expatriate-run social service has evolved to a profession led and staffed largely by local professionals. Their work has become more sophisticated, from dealing with merely financial welfare issues to providing counselling and dealing with first-world health challenges such as chronic diseases, obesity, mental health problems, addictions, discharge care arrangements and end-of-life issues.

As our population ages further and their expectations change, the medical social service must continue to evolve to stay responsive to their needs. Your profession is growing and the demand for your service will remain strong. Today, there are 200 Medical Social Workers in our public hospitals, doing very good work despite the heavy workloads. We are ramping up the number.

You are our unsung heroes, working quietly behind the scenes to help needy patients and their families tackle their problems. Your
timely interventions and your listening ears go a long way to help them cope with their illnesses and the impact on their lives. Your commitment to better the lives of your patients and your dedication to the profession has touched the lives of many. In my view, society has not sufficiently acknowledged your contribution and owes you a big debt of gratitude.

This book tries to capture some of the many heartwarming efforts put in by our unsung heroes as they go about their daily working lives. I hope it will inspire many to consider a career in Medical Social Work, a most honourable and fulfilling profession.

Mr Khaw Boon Wan,
Minister for Health,
Singapore
Preface

I was at home one Sunday afternoon and chanced to watch the repeat of the last episode of Life Transformers over one of the local free-to-air channels. This was a reality television programme where two celebrity hosts led a group of volunteers to clean up the flat of a low income family in each episode. The last episode closed with images of shock, disbelief, dismay, disappointment, anger, sadness and sorrow each time when the volunteers came face-to-face with the poor living conditions and the intractable problems these families lived under. Vicariously viewers would also have been disturbed by the various images appearing on the screen; even I was. Any reader who has watched that television programme will find this collection of Medical Social Workers’ (MSWs’) reflections palpable; better appreciate the complex milieu the MSWs work in; and possibly wonder how the MSWs handle the many difficult situations their patients present to them day after day and continue to keep at it.

Through this book the MSWs provide first-hand accounts of their patients’ experience of illnesses and the impact on them and their families as well as how they have been helped. The MSWs share openly how they were affected emotionally and, like their patients, can become vulnerable. It is therefore appropriate that both the MSWs and their patients are unidentifiable. The names used in this book have been changed, though care is taken to feature the appropriate gender and race to reflect the cultural sensitivity that MSWs have to consider in their intervention.

The MSWs involved in this project work in a range of settings (hospital, primary care and national centres); with varied client groups (children, elderly, women, the disabled, the poor);
and in diverse areas ranging from emergency, critical care, chronic illnesses, psychiatry, oncology, and palliative care. The circumstances encountered are wide-ranging, for example, the elderly patient who was neglected, the mother who lost her 24-week-old child and the mentally ill who successfully integrated into the community. They reflect the breadth of the problems and issues that come to the fore, which is an interplay of biological, physical, social, psychological, economic, structural, ethical and legal factors. This interplay of elements are like threads that are woven into and bind the fabric of life in our society. And the MSWs play the pivotal role of the weaver. As such, we have entitled our book, Tapestry of Care, as it demonstrates the broad knowledge base MSWs must possess in order to restore and maintain the beauty and strength of the fabric.

Thus, MSWs need to have knowledge in a wide range of areas including human behaviour, the social environment, social welfare policy and services, social work values and ethics, as well as medical ethics. They also need to acquire skills in social work methods, the promotion of social and economic justice, and how to deal with a culturally diverse clientele and at-risk populations. Many of the MSWs receive their professional training locally from the National University of Singapore, Monash University-Social Service Training Institute (SSTI) or SIM University. These graduates enter the profession at a young age with limited life experience. Whilst being emotionally mature, objective, and sensitive to people and their problems are vital qualities, a strong supervision structure also has to be in place to provide MSWs — particularly those new in the field — with appropriate levels of guidance and support. There are structured induction programmes, regular mentoring of handling complex cases by more experienced colleagues and ongoing upgrading of knowledge and skills to empower and help reduce emotional exhaustion and burnout among MSWs.

The fundamental approach that MSWs adopt is the systemic perspective where it recognizes that many human problems are
beyond the intra-psychic level. This book demonstrates how this approach has provided MSWs with a far greater repertoire of intervention strategies. For problems that are related to mental health concerns and interpersonal relationship, MSWs incorporate counselling services ranging from family work and therapy, psychotherapy, solution-focused therapy, grief and bereavement counselling in their clinical interventions. MSWs’ other strengths lie in their extensive experience in working with formal and informal groups in the community. This ability to work within the community has been useful in helping to develop successful linkages across the systems of care. Moreover the many of these programmes and services have criteria, processes and procedures that can be so complex that MSWs have to help to navigate and ensure patients and their families have access. Thus MSWs deal with individuals, families, groups, communities and organizations; they counsel, help their patients and their families gain access to needed services, and bring changes at the intra-psychic, interpersonal, physical, organizational, and societal levels.

Admittedly in some instances, as the book shows, MSWs may have to turn private woes into a public concern and address problems at the root which often lie beyond the individuals’ capacity to deal with them. Many social health policies affect the most vulnerable members of our society. There is potential for MSWs to contribute to social reform through social work research and the development of social and health policy. This currently is an underdeveloped area unless resources are made available to help MSWs develop the research agenda and infrastructure.

The resilience that has been displayed by the patients in the book offers inspirational reading for any one. The stories provide many case examples for social work training, discourse on contentious issues such as family care of the elderly, ethical dilemmas, access to services that can be used in any healthcare workers’ classrooms. We’ve incorporated practice pointers
in the stories, highlighted in coloured spheres and boxes. Where appropriate, these have been linked to specific points within the story. This makes the book a useful reference for any MSW.

This collection has provided a snapshot of medical social work as it is today and makes an excellent commemorative copy for its 60th year celebration. With this comes my call to Medical Social Workers to research, document and publish their work so that our readers can look forward to further publications that combine rigour, breadth and depth when we come into another milestone in 15 years’ time.

Dr Goh Soon Noi,  
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Abandonment
Human beings are formed for relationships. We need relationships to survive and flourish. Our relationship with people adds dimension, purpose and meaning to our lives. Relationships possess an enigmatic dual quality: it can be healing and constructive; it can also be hurting and destructive.

Through relationships, we can find companionship, help, encouragement and hope to sustain us in our life's journey. Yet sometimes, even in the sanctuary of a family and a home, family members can hurt and are hurt by one another. Other times family members ignore their roles and moral duty to the family when confronted with the challenges and vicissitudes of life. In our work, we witness a spouse walking out of a marriage for a new love; or a spouse who moves away because he or she can no longer endure the deficits and hardships that the partner’s illness has inflicted on the marriage and the family.

We also witness children abandoning their parents. Statistically, women have a longer life span than men in Singapore. Empirically an elderly male faces more complex discharge care issues than his female counterpart. A father is more likely than a mother to be abandoned by children. Their traditional breadwinner role had likely reduced their physical and emotional availability to the children in the latter's growing years, leading to an aloof father-child relationship.
This aloofness can be amplified by the conservative Asian culture which discourages display of the father’s emotions and affections. The elderly male patient who is now abandoned by his children could have been the irresponsible parent who left the family. Or he could be one who shirked his provider role in his lassitude, or who succumbed to the enticement of vice or of philandering in his younger years. In minority albeit increasing cases, we also see patients who have been good parents almost to a fault and yet with no culpability of their own, are abandoned by their children. Filial piety is dead in these situations.

There is always a story behind each abandonment of a parent. Regardless of whether one chooses to judge it as nemesis or conclude it as life’s unfairness or misfortune, it is painful to watch a frail, elderly patient flagging in illness and approach ageing or death alone.

What is even more painful to watch is the abandonment of vulnerable, helpless children. Children have no choice, no power and no control over the circumstances they are delivered into. Parents bring children into the world and have a moral duty to provide for and protect their children. It is a human instinct. Sadly in some cases, mankind fails this instinct.

Here are some of our encounters with abandonment.
Throughout my nine years as a Medical Social Worker (MSW), I have seen numerous patients from all walks of life with different needs, from patients looking for financial assistance to those who seek a listening ear. On some days, one leaves the office feeling mentally and emotionally exhausted at the end of a day’s work. There are moments when one gets overwhelmed with the needs of patients. Fortunately, most patients are appreciative of the work that we do and it is satisfying to know that they are managing better as a result of our practical assistance and emotional support.

Mr Toh was one patient that stood out in my memory and left an indelible impression on me. Due to an eye condition, Mr Toh found it difficult to hold down a job so his wife took on the role of the sole breadwinner in the family. He had only one son who was serving national service at the time.

Mr Toh would reek of alcohol whenever he turned up for his appointment with me. When probed about his drinking habit, he would usually be very defensive and responded in a loud voice, “How to drink? I’m not working. I have no money, you know!”

At times, when he was in a good mood, he would concede to his drinking habit, though he was careful to point out that he was not an alcoholic. “Aiyah, I never ask them for drinks. I just sit at the coffee shop and my friends will buy drinks for me. But not often… only once in a long while.”

There were also a few occasions where I found him incoherent during our sessions. I would struggle to understand
him and when I tried to clarify things with him, he would raise his voice and brush me off. Although patients do not have access to our mobile phone numbers, Mr Toh somehow managed to get hold of mine. From time to time, I would get a call from him; and when he did, he was drunk. Subsequently, I had to tell him not to call my mobile phone and explained that it was meant for my colleagues to contact me for work or emergency purposes.

Mr Toh never spoke much about his family. I remember asking him once about them and he mentioned briefly that his relationship had been severely strained due to his wayward behaviour in his younger days. His wife and son hardly talked to him at home, though he had tried many times to get a conversation going.

When his wife was diagnosed with end-stage cancer a few years later and passed away, his son left home to live with an aunt. This only further estranged father and son, and their relationship never improved thereafter. Mr Toh once showed me a photo of his son which he kept in his wallet. I noticed that his eyes sparkled when he spoke of his son as a child. It was the first time I saw Mr Toh as a father and how much he yearned for his son’s love.

There was one particular encounter with Mr Toh that is etched in my heart. He was admitted to hospital for a procedure and was due for discharge on the eve of Chinese New Year. I had to send him home as there was no escort service available that day. I was a little reluctant initially, as I was eager to rush home to spend time with my family and to prepare for my reunion dinner.
On the way home, he requested a detour to the supermarket as he wanted to get some festive goodies. With some mandarin oranges and a few cans of carbonated drinks in his hands, Mr Toh walked out of the supermarket minutes later, smiling.

At his doorstep, he was greeted by two packets of rice hanging from the gate. In the background, we could hear his neighbours doing last minute spring cleaning and children coming back from school. He invited me into his flat and showed me to a rusty old chair in the living room. The flat was dark and empty. He looked slightly embarrassed and hurried into the kitchen to put away his things. Sensing his awkwardness, I sat down and waited for him to initiate the conversation.

It was only then that it dawned on me that Mr Toh had no one in his life, no contact with his family, and no source of social support. I could not help but ask if he was having a reunion dinner with his son or any of his relatives. He did not say a word, just smiled slightly and pointed to the packets of rice. That was going to be his “reunion dinner”.

It was a simple act of escorting Mr Toh home but it changed my perception of him. Behind that loud voice and rough demeanour was actually a lonely man who yearned for family support and human connection. It is human nature to judge a person based on our presumptions and first impressions — “that difficult patient”, “that demanding and unreasonable patient”. Perhaps I had been so focused on seeing my patients just as patients that I had overlooked the most critical component in our interaction — the human element. Now, I always remind myself that my patient is a husband, wife, daughter, son, sister, brother, mother or father to someone.
Mr Toh no longer comes to the department to request financial assistance. Once in a while, I think of him and wonder how he is coping. Besides hoping his financial situation will improve, my greater desire is really to see him reconcile with his son.
Medical Social Workers (MSWs) occupy a unique vantage point in the scheme of patient care. We are intimate observers of life’s mysteries. We witness the miracles of birth and the defining moments of death. We are close to people who, under extreme circumstances, search for meaning in the midst of joy and sorrow. We toil daily to ask ourselves, what more can we offer our patients, other than providing casework, counselling and therapy? The answer is, hope.

What is hope? It is a challenge to define hope. Many confuse hope with optimism that “things will turn out right”. Yet hope does not arise from being told to “think positive”. True hope has no room for delusion. On the contrary, hope acknowledges and confronts the significant obstacles and pitfalls along the path. And yet despite these setbacks — pre-existing or unfolding — hope latches us onto the belief that we can exert some control over our situation and that we are not entirely at the mercy of life forces. This belief offers that glimmer of light and that additional atom of energy to endure and achieve despite our circumstances. True hope gives patients the courage to confront their conditions and the capacity to surmount them. True hope gives realism; it gives strength. It nourishes the mind, body and spirit while the individual continues on his journey fighting the illness.
The stories in this section portray how MSWs mine for hope in their work with patients to help them expand their options out of their doldrums and adversities. How then can MSWs help their patients find hope and transcend their illnesses or life's predicaments? Life has to be lived with a purpose. An important element in our work is to help patients find meaning in their suffering, so that their illness experience becomes purposeful. When there is a purpose, there is a reason to endure one’s circumstances. We talk to them, we listen to them. We help them search within themselves for the strengths and resources to cross life’s hurdles. We awaken in them this awareness that they have the ability to choose their attitude in a given set of circumstances, however grim the situation may be. We cannot tell them what their purpose for living and suffering is. Each must find out for him- or herself.

From these stories, we see that hope takes on many forms: the unyielding hope, a courageous will, a staunch determination, the fortitude to fight; hope that musters the will to engage the foe and hope that gives strength to sustain the illness battle. The hope that our patients don becomes their armour against the assaults that life and illness wage against them. When we witness hope in our patients, we, like them, have something to look forward to.
"Ma… Ma… why have you gone before me and left me all alone in this world? I want to be with you. I miss you so much… Ma… Ma…” he cried out like a lost child, eyes tightly closed; his fingers tightly clutching a passport-sized monochrome photograph of his mother in her younger days.

Other than me, there was no one in the room. Mr Woo was having a conversation with his dearest mother who had passed away ten years before. I sat next to him, speechless and at a loss as to what to do next. He was in a state of delirium; inconsolable and refusing to be consoled. His eyes scanned the room and his hands sprawled across the desk nearest to him for an object which could end it all. “Let me kill myself! Just let me die!” he yelled across the room.

He desperately wanted to end this seemingly meaningless existence on earth. What could one do or say to someone who seemed to have lost all reason and hope for living, the essence of life itself?

Just two months ago, Mr Woo approached me requesting financial assistance with his medical bills. He portrayed himself as a meek, quiet and courteous gentleman in his late 50s who desired nothing but to live a simple life. This was apparent in the number of “thank you's” and “don’t worry, I can (cope)” uttered countless times when I offered him assistance in view of his financial difficulties.

Mr Woo was one who was contented to have a roof over his head which translated to a small room in a backpacker’s hostel, three daily meals usually of bread and biscuits, and the occasional packet of rice from the coffee shop near by. What he earned as a part-time security officer usually either allowed him to pay for his hostel rent or for his food.
An optimal control of diabetes requires patients to not only be compliant with their medical treatment (for example, taking their oral medication or taking their insulin injections correctly and regularly), but also requires a significant change in their lifestyle habits. Patients need to observe a balanced and nutritious diet to regulate their blood glucose levels and also exercise regularly to keep their weight within an acceptable range. In the case of Mr Woo, his financial difficulties prevented him from buying “healthier” and more nutritious food which would have helped in the better management of his diabetic condition. For example, whilst diabetic patients are often advised by dieticians to eat food low in saturated fats, lower income patients have difficulty affording such food items. They may end up buying food with high levels of preservatives and sodium which can be kept for a longer period of time and such foods are usually cheaper as well. Low income patients frequently rely on canned food and instant noodles, which are high in sodium. This can affect the treatment effectiveness.
required him to constantly keep tabs of his blood glucose level and maintain a healthy lifestyle, which was difficult with his meagre income. Food is the most “elastic” item in the expenditure of the working class, since the amount spent on this item can be stretched, either more or less, according to whatever money is left after all other bills which must be paid are settled. Mr Woo fitted this hypothesis to a tee; and I wondered to myself how many days went past with him just surviving on instant noodles or some crackers and plain water to save enough for his hostel accommodation charges. And this phenomenon is not unique to Mr Woo. Many of our poor patients scrimp on food. So even though they receive Medifund assistance for their treatment, their nutritional needs are not adequately met, hence limiting attainment of the desired health outcome.

Supportive counselling was provided for Mr Woo and monetary assistance was urgently rendered from our own department’s funds so he could have proper nutrition to combat the weight loss from inadequate and deficient nutrition, as well as poorly managed diabetes. I thought that the money would tide him through the predicament that he was in; however, nothing prepared me for this unexpected phone call when he called to say “good bye and thank you”. He told me that he was at a high risk of losing his job and that he could no longer afford to rent a room at the hostel. A friend of his who had offered to let him stay at his place had a change of heart. Mr Woo was also convinced that no one should bear the burden of his difficult circumstances for his mother had always told him, “Work hard and depend on your own abilities”. He then hung up.

I panicked and my heart raced as I feverishly tried to call Mr Woo back. Finally and thankfully, he responded and was willing to return for his “last meeting” with his Medical Social Worker (MSW). What happened in the next two hours was a blur as he hung on to the tenuous thread between life and death, oscillating between delirium and coherence. At times, he would be yelling and calling for his mother and at other moments he seemed very much “himself”,

apologizing and pleading softly to let him go home and to “go down”. Yet in either instances, it was clear that his life was in danger.

Mr Woo was eventually escorted by security officers to a psychiatric ward to be treated for depression after he put up a fierce struggle and made countless threats. He evidently could not keep himself safe.

I was apprehensive and nervous as I walked towards Mr Woo’s ward that same evening when hope and life was almost lost. “Will he detest me for stopping him from ending his life? What will he say to me? Will he be upset?” I thought to myself as I gingerly approached his bedside.

My anxiety dissipated when he greeted me with a smile as I approached him. “Miss Liew, thank you for saving my life. I am very grateful.” Seated by his bedside was his cousin whom my colleague and I managed to contact. Mr Woo had previously given us his cousin’s name to bid “goodbye” to him when he was in his active suicidal state. The irony was that despite Mr Woo’s perceived absence of personal social support, his cousin proved to be a good source of emotional support for him and promised to watch over him. It was a precious lifeline for Mr Woo. I realized then that perhaps people who perceived themselves as “loners” and uncared for by others may in reality not be that alone after all. In their moments of desperation, a ray of hope — even if faint — can illuminate life’s path. And that was the symbolism behind the appearance of Mr Woo’s cousin.

In the meantime, plans were made for Mr Woo’s accommodation in a community home for the elderly and that gave him hope. Once again, circumstances were quickly against Mr Woo as he was found six months short of the minimum age requirement of 60 years for admission. An appeal implied a longer waiting time as approval from the Ministry was needed. Since he was medically fit for discharge, I was under pressure — intensified by incessant calls from the ward...
— to discharge Mr Woo, who had no place to call home. The poor man was emotionally too frail to face another setback.

Hope arrived. After a series of phone calls and appeals, Mr Woo was promptly admitted to a community home just two days later. This quick reply from the home was an exception rather than a

The bed crunch situation: all restructured hospitals in Singapore offer subsidized rates of medical treatment for Singapore citizens. Permanent residents enjoy such subsidies, although at a lower percentage. Presently there are only six such hospitals located in various parts of the island. As a result, the demand for hospital beds usually exceeds the supply since such restructured hospitals cater to the majority of Singaporeans who desire and opt for the subsidies available.

Patients and families may have an erroneous expectation that patients can continue staying in the hospital until they are fully recovered. Recovery for illness can take significant time. For some illnesses, there may never be full recovery and the aim is for patients to achieve optimal functional status. Thus, there is often a call by the medical team to expedite discharging a patient back home or to a step-down institution as soon as the patient is medically fit and has no need for active medical treatment (e.g. surgery, intravenous medication). This is to allow other incoming patients a chance for admission and to receive timely medical treatment.

Another reason why patients have to be discharged promptly is the risk of re-infection. As patients tend to have lower immunity when they are ill and are more prone to cross-infections from other patients in the ward, patients are advised to be discharged home once assessed to be medically fit. To reduce the hospital bed crunch, there are intermediate and long-term care (ILTC) facilities in the community to cater to the needs of individual patients. With an ageing population, there is a high demand for these ILTC facilities.
norm. Owing to placement vacancy limitations, MSWs often have to make repeated appeals to institutions to expedite their placement applications, especially for those who fall through the gaps.

Work for me went on as usual after Mr Woo was discharged, busy and hectic. It was not until I was attending an event organized by the Police Force during the Chinese New Year season a month later that I spotted a familiar face amongst the sea of faces around me. It was Mr Woo, smiling contentedly and looking significantly healthier as he chatted with two senior citizens sitting next to him, dishing out New Year goodies to his new-found friends.

My gaze lingered on him a while longer before I turned back to the plate of food before me and grinned in delight.