Giving, Not Just Taking

By Chie Zhi Ying

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Mention Dr Wong Chiang Yin's name and a few things come to mind – public health physician, and past Chief Operating Officer of Singapore and Changi General Hospitals. Having stepped down from the SMA presidency after being at the helm for three years, Dr Wong continues to contribute to its vigour and growth as a Council member. Despite his busy schedule, he generously shared his insights and wisdom with Chie Zhi Ying (YLLSoM Year 3).

Chie Zhi Ying – CZY: Why the choice to go into Public Health? You have an MBA degree from University of Leicester; how has it helped you in your career as a hospital administrator?

Dr Wong Chiang Yin – WCY: I think having an MBA in Finance is useful and so is having an M.Med in Public Health. I took up an MBA because in our time, we had to take triple science in the "A" Levels and I also did pure science (i.e. Biology, Chemistry and Physics) at the "O" Levels, so I had no formal education in economics or finance before I entered NUS Medicine. I thought not knowing economics or finance is a big blind spot I could not afford to have if I was to be good in my field of work.

I more or less stumbled into Public Health when I was offered the post of medical officer in the newly set up Department of Traditional Chinese Medicine (TCM) in the Ministry of Health. The department was set up to regulate TCM and TCM practitioners, and I took up the post because I didn't have any burning specialisation plans. I didn't actually know how to be a TCM practitioner but I spent quite a fair bit of time with the TCM practitioner community, which was a very educational experience.

I think as a hospital administrator, one has to know public health principles well and also know how to run a business. Having both an M.Med (Public Health) and an MBA (Finance) helps.

CZY: As the past President of SMA, what are the milestones that you have achieved? Tell us more about your experience in leading SMA.

WCY: The job of the SMA President is never finished, and it just passes from one person to another. Like my predecessors, I just wanted to hand over SMA in a better shape than I had found it in to my successor. The quest for a bigger, stronger and more relevant SMA never ends.

I don't really take these as milestones, but some of the developments that happened on my watch were: Senior Minister Goh Chok Tong's acceptance of the SMA Honorary Membership; the reluctant withdrawal of the Guideline on Fees when the Competition Act came into force; and the setting up of the SMA Medical Students' Assistance Fund.

My experience as SMA President was rewarding, challenging, and above all, contemplative. I became President a few weeks short of my 38th birthday and I recognised from the outset that relative youth may be both a disadvantage and an asset when it

comes to the SMA presidency. I was fortunate that in my three years as President, I did not face any major disease outbreaks like SARS or H1N1, and I had the luxury of time and resources to strengthen SMA's standing with doctors and the public. I think one of the big challenges was how to communicate effectively with 4,000 to 5,000 members all over Singapore. My own way was to communicate via the President's Forum in *SMA News*. I wrote 37 columns in my three years as President, and I received a fair bit of positive feedback about them from doctors.

CZY: You wear many hats: Public Health physician, past President of SMA and Council member in the Academy of Medicine, Singapore (AMS). How do you manage to juggle all these roles well? What are the challenges that you face?

WCY: Time is the only asset one cannot store up now and use later. So I try to maximise my time every day. I suppose the fact that I don't have a family gives me more time, but I don't suggest that as a strategy for anybody!

CZY: Tell us what a typical day of work is like for you. What are your favourite pastimes? How do you think one can achieve work-life balance?

WCY: I don't think I have achieved work-life balance yet, so I don't think I can comment on how one can achieve it.

My time is spent as a consultant to a private healthcare company, and as senior consultant in a public sector healthcare agency. What remains is spent being a Council member of SMA and a censor in AMS.

My favourite pastimes are reading, swimming, photography and Chinese calligraphy. I have too many hobbies and don't have time for them all!

CZY: In your opinion, what are some of the challenges that our healthcare system will face in the next 10 to 20 years?

WCY: Let's start with what the three most important questions are. To me, the first question is, how to fund healthcare properly? Having gotten the money well, the second question is, how do we set up a system that can utilise the funding correctly? Finally, after having set up systems to get funding and use the funding, how do we then get the right ethics in place so that the system is not undermined by healthcare professionals, because the ethical framework is not right?

The first question, on healthcare financing – we need discipline to ensure that each generation pays for its own healthcare costs and not transfer the liabilities to the next generation. We have a predominantly savings-based model (Medisave and MediShield) which now ensures that each family and generation pays for its own medical expenses. Sometimes we take it for granted. In most countries, healthcare financing is on a "pay-as-you-go" taxation system, whereby at any one time, the working-age group (healthy) is paying for the preceding generation's (elderly and usually less healthy) medical expenses. A moral hazard or "buffet mentality" is also common amongst the populace. The demographics of a developed country usually doesn't permit this "pay as you go" method without heavy taxation, but there is often no political will or public discipline to break this vicious cycle. Singapore thankfully hasn't entered into this vicious cycle, and we should do our best to keep it this way.

As for the second question – optimisation of healthcare and choice – it may seem obvious that we should pursue these concepts relentlessly. How do we maximise resources? How do we get more done for less? We should cut wastage as far as possible, but the reality is that sometimes, we can optimise to the point of vulnerability. Maximum optimisation takes place only under certain assumptions and conditions, such as a stable environment. But in the process of optimisation, we can spread ourselves so thin such that the system cannot accommodate changes in the operating environment, for instance in a communicable disease outbreak, a natural disaster and so on.

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On the other hand, we are made to believe that choice is always good. Choice is freedom. Choice is power to the patient/consumer. And there is no downside for a person to be given a choice. But the fact is choice costs. There is a cost to offering the patient many choices: there is a cost to offering many classes of beds to a patient or having a big formulary stocking many different drugs. Choice can drive up healthcare costs too when it brings about unnecessary complexity in the operating environment. We now take as a joke the famous quote by Henry Ford, "Any customer can have a car painted any colour that he wants, so long as it is black." But there is a lot of wisdom in what he said. I think we need to remind ourselves that we should not offer choices frivolously and at the same time, we should not optimise our healthcare system and institutions to vulnerability. Balance and good judgement is needed here.

And the third question – ethics and the threat to the doctor-patient relationship. The doctor-patient relationship and the ethics of medicine are symbiotic, and the two are fundamental to healthcare after we have answered the first two questions. I think over the last 15 years, marketplace practices have increasingly dominated the practice of medicine. When I graduated 16 years

ago, doctors and clinics were not allowed to advertise. Now advertising and promotion is rampant. Is that a good thing? Healthcare is an example of market failure and market forces are only a good thing if we can harness and control it in healthcare. But it seems to me increasingly that many believe that having the market predominate in healthcare is an end in itself. That's what some people call "market fundamentalism".

I also see increasing shades of legalism encroaching on the practice of medicine. How do we keep our doctors ethical in the face of the forces of over-commercialisation, market fundamentalism and legalism? How do we prevent doctors from practising defensive medicine when the environment is getting more and more legalistic? The law is there to protect the aggrieved, but the law is really "after the fact" in that sense. We may be able to pass a law that enforces children to look after their parents financially after we prove that the parents have been denied support, but we cannot pass laws to enforce love between parents and children in real time. Similarly, we cannot really enact more laws or use market forces to enforce a good doctor-patient relationship. We need ethics and professionalism to inculcate the relationship. I think market fundamentalism, over-commercialisation and adopting an overly legalistic approach can sometimes undermine a healthy relationship between human beings – and the doctor-patient relationship is really a relationship between human beings.

CZY: In your view, what makes a good doctor? What are the values that you believe in strongly or any personal motto you would like to share?

"But meritocracy is not about the best taking as much as possible from the rest. That is only possible in the long run if the meritorious (those deserving of merit – all of you taking subsidised education in this medical school) give back to society by being competent and ethical doctors. We also continue to attract the best into our ranks by doing so. If many doctors become unethical, greedy or incompetent, then society may decide they will stop supporting this system of meritocracy or holding doctors in high esteem. Then, the best in ability may not join the profession. Once we get into this downward spiral, we are finished."

WCY: The practice of medicine may change but the values are always the same. As William Osler said, "Equanimity and imperturbability are important qualities that a good doctor should have." Other underrated values include humility, decisiveness and a strong sense of morality – to instinctively know what is right or wrong. Of course, a good doctor must be a good listener, a good communicator and be able to empathise. One of the most difficult skills a doctor has to learn, which is seldom taught well, is to understand human behaviour. Not just the behaviour of patients, but the behaviour of your fellow doctors, nurses, allied health colleagues and hospital administrators as well. I haven't really thought about having a personal motto. I only have my old school motto, "The Best is Yet to Be".

CZY: Any golden words of advice to current medical students?

WCY: No golden words. Just plain talk.

The first point is about the decision to specialise. It is one of the most important decisions you make in your life. The opportunity to choose a residency programme in your final year is here now. But do not let that opportunity dictate your decision-making process. In my time, our seniors and bosses told us to take our time to really know what we wanted before making that decision. I think that is sound advice. Perhaps the average M5 student today is a lot more mature than those who came before them, but as for myself, I certainly couldn't have made a good or mature decision if I had to make one in M5.

The second point is about meritocracy. Current medical students in YLLSoM are the products of meritocracy. Put it another way, you are here because you are supposed to be very good, if not the best. You are here also to receive a study grant/subsidy of about $350,000 to $400,000 over five years, or $70,000 to $80,000 a year. The median Singapore family income is now about $60,000 a year. In other words, one can feed a family of four for a year with the amount of subsidy each of you are receiving yearly as a medical student in YLLSoM. And after that, you will earn a relatively high salary. But meritocracy is not about the best taking as much as possible from the rest. That is only possible in the long run if the meritorious (those deserving of merit – all of you taking subsidised education in this medical school) give back to society by being competent and ethical doctors. We also continue to attract the best into our ranks by doing so.

If many doctors become unethical, greedy or incompetent, then society may decide they will stop supporting this system of meritocracy or holding doctors in high esteem. Then, the best in ability may not join the profession. Once we get into this downward spiral, we are finished. You can see how many countries are highly critical of the extremely high earnings of some investment bankers, and how their governments are trying to limit or claw back some bankers' hefty bonuses in the last two years. You can also come to the conclusion that with privileges (of subsidised education, high social status, good pay and so on) comes social and moral responsibility. Meritocracy is about giving, not just taking. SMA