Making a Difference

By Dr Tan Yia Swam, Deputy Editor

One gets a glimpse into Prof Philip Choo's management philosophy as the Chief Executive Officer (CEO) of Tan Tock Seng Hospital (TTSH) by looking at the posters of systems thinking models plastered on the walls of his office. He started out as a geriatrician in TTSH, and has held a number of positions at the hospital, including Head of Geriatric Medicine, Head of General Medicine, and Chairman, Medical Board (CMB), before assuming his present position in 2011. Currently, he is also the Deputy Group CEO (Regional Health) at National Healthcare Group. Prof Choo shares his gradual journey from clinical Medicine to healthcare management.

Growing up

Dr Tan Yia Swam – TYS: Tell us a bit more about yourself.

Prof Philip Choo – PC: I am the third of four siblings, and my father was a GP for many years. He started in Singapore and then shifted to Malaysia, mainly because my mother was a Kelantanese. My childhood in Malaysia was quite fun and a lot more carefree.

My siblings and I moved across to Singapore when I was in primary school. This was after the 13 May 1969 racial riots (in Kuala Lumpur), and we were essentially separated from our parents. Actually in Kelantan, we never heard of the riots. Some of my best friends were actually Malays.

My parents sent us over to Singapore not so much for safety reasons, but more for our long term careers. At that point in time after the riots, the Malaysian educational system was changed and lessons were taught in Malay. My parents felt that our futures would be better if we studied in English.

We would go back to Malaysia for holidays, but were mostly on our own. The distance taught us to be independent, and brought us closer to one another.

TYS: Did you have fond memories of school?

PC: I was in St Michael's Primary School and moved on to St Joseph's Institution (SJI). I liked SJI; it was a fun place to be in. Each year had 14 classes, and we were streamed into the Arts, Science and Technical streams in Secondary 3. The first two classes were considered "good" and the rest just made up the bulk of the population. I was in the Science class, and there was a great variation of students in each year.

I soon realised that the success we see in school may not translate into real life. At class reunions, I found out that many from the other classes have become successful. They have taken a more interesting and winding road, which led to where they are today. The journey helped mature and develop skills. While some people are better at studying, others are better in other aspects, and people mature at different ages. The surprising thing is that the vast majority of people do manage to succeed and turn out quite well. After SJI, I was part of the first batch who entered Catholic Junior College.

TYS: What was your National Service (NS) experience like, and what did it teach you?

PC: There were two parts to it: firstly the initial six months before disruption, and secondly after medical school. The first part was a real pain. The second, I enjoyed, mainly because the unit I was in allowed me to do a lot of things. I served in the air force as a medical officer. It was not only an operationally ready unit, but also a factory because much maintenance work needed to be done. This included public health issues, and I remember introducing a lot of screenings and we were able to come up with recommendations for noise protection, and so on, that were not in place at the point in time. It was useful and good learning for me. In all, I quite enjoyed my experience.

TYS: What made you decide on Medicine as a career?

PC: Firstly, I was terrible at Maths and Engineering was not an option. I was from the Science stream, which meant that many options available to those in Arts were not for me.

Another reason was my father. He was a GP so Medicine was something I wanted to do. Of all my siblings, I was the only one who took up Medicine. My sisters took up Accountancy and Business Administration, both entered the financial line. My brother studied Engineering in the UK and then went into business management.

In Medicine, we have a long and protracted training period – basic degree, postgraduate degree and then advanced training. Even as a consultant, there are still things to learn. In other disciplines, the learning curve is much shorter and many do not require a postgraduate degree. And I am the only one in my family who is still working – everyone else retired a long time ago!

Going into Medicine

TYS: Was there a reason why you chose to enter Geriatrics?

PC: In medical school, I was dead sure I was going to be a GP, and had planned with some friends when to exit. By and large, this group still exists and many are successful. The turning point was my hospital posting in the last six months of my NS. I was posted to Medicine at the department and hospital where I was a houseman. That was Medical Unit 1 at TTSH under Dr F Jayaratnam. Dr Jayaratnam was a good, caring doctor with high ideals and principles. He was fair, had very high expectations and we had to work very hard under him. I decided to stay on in hospital practice after being inspired by him.

As to why I chose Geriatrics, at that point in time after you got your MRCP, you had to decide what else you wanted to do. It's very strange as all your training till then teaches you everything as a whole. Then with subspecialising, the focus narrows to just one part, for example, Endocrinology or Neurology, and you don't see the person as a whole anymore. I wanted to treat the patient as a whole, and my options were General Medicine, Geriatrics or Paediatrics. I felt only Geriatrics allowed me to view and manage patients as a whole.

In my last year before I sat for my exams, I spent my time in Medical Unit 1 at Singapore General Hospital (SGH) under Prof Cheah Jin Seng, a great and caring mentor. I enjoyed my year, and we had a good pool of people. Prof Cheah and my seniors tried to convince me not to enter Geriatrics. I was the first person to be sent across into Geriatrics, and at that point in time, it was unheard of. No one was sure where it would be, so they were trying to keep me in SGH and offered me other options. I told them that I had given my commitment to Dr Jayaratnam that I would return after I graduated and was obligated to do so. Back then, it was considered very risky. Even during my final year of medical school, the term "Geriatric Medicine" was unheard of. I never knew it existed and it was a new specialty. Most people had considered it a foolish move.

From Medicine to management

TYS: How did you make the shift from clinical Medicine to healthcare management?

PC: It was a very slow shift that I did not quite realise was taking place while doing Geriatrics and working with my previous boss! There was a gap of more than 20 years between the both of us. When I was a houseman, he was already my Head of Department. I succeeded him at a fairly young age. I also became CMB of TTSH at a young age, although by that time, I had spent many years as the Head of Geriatrics. This put me as one of the most senior heads but the most junior in terms of age.

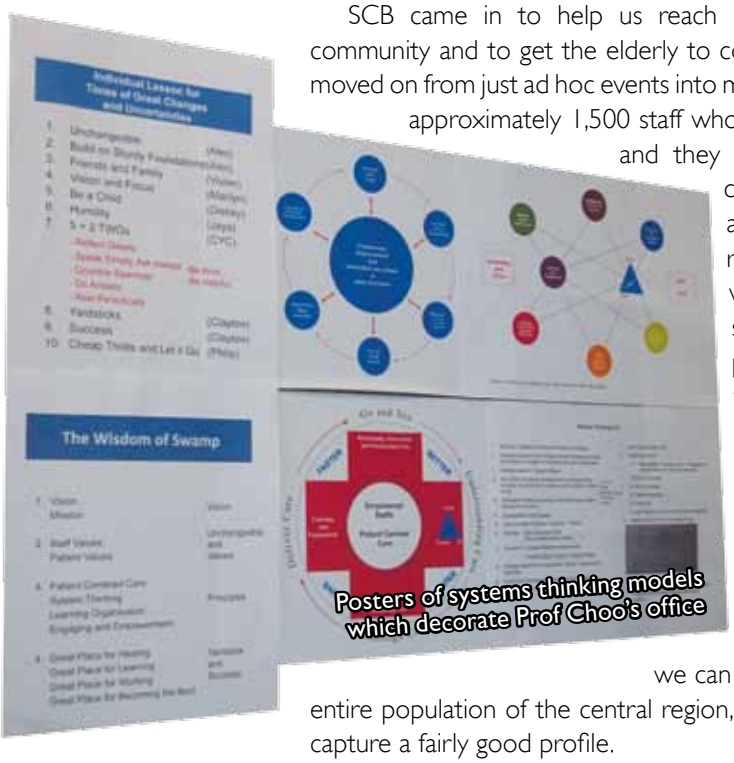
As CMB, it is very difficult to separate clinical from operational areas because the development of services and other aspects are tightly interlinked. If you are unable to appreciate the processes and ways of doing things, it gets difficult. As head and then CMB, I started doing a lot of this sort of work early on. I also took over as the CEO of TTSH after my predecessor left.

TYS: What is your typical day like?

PC: I usually arrive at work before 7 am, because I have to send my kids to school.

The first hour is very important, as it allows me to finish up paperwork and clear emails that have accumulated during the night. From 8 am onwards, there is usually a series of meetings that take up the rest of the day. Hospital functions are getting wider and more complicated, but many of these are things that have to be dealt with as they are bread and butter issues. Others occur because we are planning things in the pipeline, such as rebuilding or other massive projects. There are also other meetings because we are planning a change of direction and medical services, as we are building and expanding our community arm. It's important to show up and to this day, each time there is a brief for the programmes, I turn up at least at the beginning and at the end to show support.

All these things take up quite a bit of time, and it's a mixture of items for the maintenance of the hospital, planning for the future and also construction and development of buildings. The things that give me joy are the few clinical sessions I have left, as well as teaching. You can get fast rewards from these; the gratification is immediate when you see patients or teach. When you do administration, the gratification is long delayed though the impact is far greater. There needs to be a balance between those two things.



Posters of systems thinking models which decorate Prof Choo's office

TYS: TTSH is now known as one of the best places with a strong Geriatrics department, for coordination of care for the elderly in the community. You must have contributed a very large part to that.

PC: I've come to realise that the culture and behaviour of a department is inherited. That's why there are different norms across different departments. A lot of the culture has been passed on from the original people, the pioneers, such as Dr Jayaratnam, myself and other colleagues. Subsequent heads have been told to maintain the same type of culture, outlook and ways of treating patients. Culture is important as it shapes discipline and the way things grow and how people behave. These are the unspoken rules and value system, and we sometimes underestimate that.

TYS: There's been much development in recent years, such as migration of the A&E, shifting of long stayers to Ren Ci Community Hospital for step-down care, and planning for the new medical school. In addition, there is also a partnership between TTSH and Standard Chartered Bank (SCB) for the elderly. Can you tell us more about it?

PC: This stemmed from one of the community programmes, called Community Health Engagement Programme. We identified a few blocks of single room flats in Toa Payoh, and assessed the profile of the inhabitants. We found that some of them had been unknown to the system, and they had significant health issues such as depression, almost a third had visual or hearing difficulties, many had experienced falls, while a large proportion had chronic diseases which were not well managed. We thus tried to do a series of interventions, one of which was fall prevention. The programme aimed to improve the inhabitants' strength and gait.

SCB came in to help us reach out to the wider community and to get the elderly to come take part. We moved on from just ad hoc events into more areas. SCB has approximately 1,500 staff who actively volunteer, and they have a culture of contributing back as part of social responsibility. We work with them on some community projects. We are thinking of doing a community survey conducted by SCB volunteers, to go into houses to perform simple checks and ask some questions. If we can do that across the entire population of the central region, we will be able to capture a fairly good profile.

We know the profile of patients in hospitals, polyclinics,and so on, but not those outside our system. In administering population health, you will need to know all profiles within the population. From there, you identify the subpopulations at risk, and then develop intervention tools. This is a good project to do, and we are trying to tie up with one of the community development councils as well, so we can train volunteers to go house to house. We are hopeful that over time, we will be able to know what the population in the central zone is like.

TYS: As CEO, how do you deal with patient complaints and compliments?

PC: That's a real tough question. There has been a clear change in terms of population expectations. One is that they give feedback far more frequently because the expectations

are far higher. Complaints are escalated far more quickly to ministers or the Prime Minister. When we do investigations, we find that a lot of it is due to miscommunication or stresses of the system; we are not spending the amount of time that we should on appropriate communications, explanations, or conferences with the family. A lot of it is due to the perception the family has – that they are not getting the care that is appropriate or due. Much is also due to inadequate explanation on our part. There are basic requirements that patients want from us and they get upset when they feel that we have failed to deliver. What we need to do over time is to make sure that all these are delivered.

Much of the feedback coming in is because of the increased complexity of our patients. There are hardly any patients with single diseases anymore, and this means we need a team of people to look after them. Coordination then becomes a challenge and more matters require ironing out now. I find that part of it is in the training of medical students, where we teach them from a single disease approach – everything in history is tied to one diagnosis – but in truth, that no longer happens.

I haven't seen a change that teaches us to take history differently. We need to be able to do that. Secondly, it is almost impossible now for just one person to deliver the full spectrum of care. Care is now delivered through a group of people – not just doctors, but therapists, nurses and coordinators. We haven't actually trained people on how to work in teams, or taught clinicians how to organise care in teams for efficiency. As such, I find that we are not as well coordinated as other industries. In truth, we still train nurses, doctors and social workers in silos. They don't cross, but the moment these people graduate and work in real life, they have to work in teams! It is very hard to work in teams if you've never learnt to do so before. These are real issues and we need to figure out how to incorporate them into our training programmes in the undergraduate or residency programmes.

Thoughts on local healthcare

TYS: What are your views of the challenges that Singapore healthcare faces?

PC: To date, our cost has been fairly low but this is because Singapore was, till recently, a young population. When you are young, you find that your requirements are episodic in nature. Patients will come in for a short stay and then be discharged. We are rapidly changing into an ageing population, and as part of the culture and way we live, the instances of chronic diseases are increasing dramatically. This means we have people who have health problems but live with them. Sometimes, they not only require acute care, but also have to undergo a slow period of recovery. We are unable to cure them from chronic diseases, and they tend to decline in function with age.

With such a population, episodic care has been shown not to work and you find that when you take that approach, healthcare becomes very expensive and unsustainable. To keep it sustainable, you will have to reshape healthcare because patients have existing problems before they come in and after they leave. You need to focus on prevention and not wait for patients to turn up. You also need to create new goods in the basket because aside from acute hospitals, outpatient clinics and nursing homes, there are very few things in between. If someone requires a service that is more than an office consult, it becomes hospital-based. To be cost efficient, you must have services that match that need. So a lot of what we are doing now is creating new services such as community rehabilitation. This can narrow the gap between community hospital discharge and home servicing.

Like all good students staying in the university hostel, Prof Choo didn't attend lectures so he was not in his medical class photo

Prof Choo (left) with then Health Minister George Yeo (centre) and then TTSH CEO, Dr Judy Lim (right) touring TTSH

We now need to be able to reshape our services, and tie them together to ensure an efficient flow. In addition, we also need to train people to do these things – via either integration or a regional healthcare system. The four streams needed of a regional healthcare system are: caring for the acutely unwell and flowing them out to the community, management of chronic diseases, maintaining the elderly who have completed treatment, and identifying and creating intervention programmes for the population at risk. We need to be able to do all four, but the major issue is that not all these streams exist at present.

Doctors must be trained differently. You need to have many geriatricians or those with Family Medicine and Geriatrics training in order to look after the elderly in the community hospitals, or perform maintenance in the community. That part is something that we have not thought of or created career tracks for. Those are the challenges. In a country that does this well, healthcare costs are far lower. Conversely, countries that don't do it well have tremendous costs. It has nothing to do with the number of people or even medical knowledge, but a combination of the two and the ability to integrate both well that makes healthcare affordable. This is something we are new at.

TYS: Are there countries who have managed to do this well?

PC: There are very few countries that exhibit good, solid examples of doing this well. Recently, a few of my colleagues and I went to visit The King's Fund (an independent charitable organisation that works to improve healthcare in the UK), which has been around for a number of years, looking into integration and demonstration of good models. They told us that there are less than ten good models, so you can see that it is tough to do, and even tougher to do it well. Everybody is on the same starting line and the challenge for us is to be the 11th country. (*laughs*)

TYS: I can imagine. You need resources, government support, and for people's mindsets to change and accept.

PC: Correct, within the hospital too, you need to reorganise everything, such as the outpatient sectors, as well as medical centres, and even floorings. We now realise that when people come in, they tend to be cross-referred to different disciplines and we have to group them on the same floor. These disciplines now also tend to require lots of support and services, such as Radiology. And if numbers are high enough, we need to put a satellite service out there too. So for example, we put out Medical Oncology together with Palliative Care, as well as inbuilt pharmacies on the same floor. That floor then needs special arrangements such as lab ware facilities because all Oncology patients need to get their results fast.

Another example is the musculoskeletal floor where we have Rheumatology, Orthopaedics, Sports Medicine and therapist services. We even have to put in minor theatres into the outpatient area together with X-rays and pharmacies because patient numbers are so huge. In this way, the patients don't have to leave a particular floor.

The moment patients make multiple journeys, it slows everything down and our system jams. That's for outpatients. We need to employ the same thinking for inpatients too.

TYS: In relation to cost effectiveness, what are your thoughts on national health insurance, public-private partnerships and portable subsidies?

PC: Tough question. In terms of healthcare costs and how people pay for them, there are only a few ways. Firstly, we pay as a society, as a group of individuals together and that is through taxation. This is then used in the form of either subsidies or the purchase of a national insurance scheme, for example, the UK's National Healthcare Service.

Another way of going about it is paying as individuals, which means either out of pocket or buying insurance. If you want to make healthcare affordable for individuals, here is where insurance comes in. But for insurance to work, there needs to be a few assumptions – that there is a big enough pool so as to prevent cherry picking. If you allow cherry picking, what's left will be the high risk individuals who have no way of paying for healthcare. Insurance only works if occurrences are quite rare. If they are common, then it won't work. Based on this, insurance comes in to pay for rare, major and expensive incidents requiring hospital stays. For the bulk of it, people have to pay on their own.

What has changed over time is that we have shifted a lot of inpatient care into the outpatient setting, and that makes out of pocket payment for ambulatory care quite expensive. Combined with the fact that many conditions now are chronic in nature, insurance is now creeping into these. But if you extend insurance into all these areas, premium of course increases in tandem with higher incidences. The only thing you can do now to balance healthcare cost is to make sure the pool is wide. That has been part of the model that we have adopted. And if we are talking about the majority of the population, our basic level insurance actually covers most items to treat patients in a subsidised fashion but it covers a whole range of conditions. That's a fairly good way to develop it. There is a tendency for people to want to buy, use and demand a lot of things from insurance because they have already prepaid a small premium.

One of the things you need to put into the insurance system is to counter this natural tendency, and the element of copayment policy must come in as people will overuse it.

TYS: As the CEO of TTSH, what are your thoughts on Mount Elizabeth Novena and its impact on TTSH?

PC: We are two very different hospitals. I have been to the hospital next door and it's very nice both inside and outside. It is built and catered for a population that is entirely different from ours, and the market strategy is small volume but high premium, focusing on mainly elective work. They keep their cost structure to a minimum through this. When you do elective work, you require far less manpower or 24-hour backing because most of your patients are well and walking. They come in, get their procedure done, and walk out.

Acute hospitals are a different story because the patients are very unwell and require a whole team to maintain them. The new hospital caters to a smaller proportion of patients who are prepared and willing to pay in terms of selection of doctors, time and service. Based on this, we don't exactly compete in terms of patients. What we do compete on is manpower. We use the same nurses, administrators and doctors. And that can be an issue. Some of the doctors there were formerly from this hospital.

TYS: What do you feel about doctors who leave the public sector?

PC: I think it's a choice that everyone has to make at different times of his or her lives. I do not see it as a right or wrong one. A lot of doctors who left us were very good ones, and had contributed and served TTSH for many years. At a certain point in their life, they decided that there were other things that they wanted to do. Would I have welcomed them to stay longer with us? Yes, definitely, but I can also understand their other needs.

What we need to do is ask ourselves what else the hospital can do to keep them. I can understand the reasons why they leave. They may have worked with us for a certain number of years, and we do have a very high workload and acute system. That requires a certain amount of commitment and a certain lifestyle, and people do want balance in their lives. We need to see, while working where we are, how we can make the working hours better or remove some of the things that doctors don't want to do. Administration and other aspects take up a lot of time, so we need to be able to put in more support system so doctors do less of that and more of what they want, be it teaching or seeing patients.

How do I improve the pluses? As a hospital, it is always important to maintain a certain level of seniority of staff because they bring with them experience and more importantly, judgement. Increasingly today, it is not so much the technical skills or knowledge, but deciding when to apply for which patient. In this regard, judgement is especially important. Unfortunately, you need a certain amount of experience and must have seen enough patients before you are able to know.

TYS: Do you foresee yourself going into private practice one day?

PC: No, I think I have crossed that line. (*laughs*) But I have received many offers, and to my surprise, another one just last week. This was from the UK, and asked if I would like to work in the Bahamas with my family. Over the last couple of years, there have been some interesting offers, but I have many challenges here. What is unique about the Singapore healthcare system is it allows us leeway to innovate and

bring in changes to our infrastructure. There are many exciting things to do.

TYS: You mentioned that experience is needed to make decisions.

PC: Yes, but you need to balance that. It's not just doing things in a repeated fashion. What we've learnt from people in aviation or sports is learning through deliberate practice – looking back on the outcomes and learning what can be done to change the outcome for better or worse. This actually teaches us far more.

When we are very busy, sometimes we don't reflect or look back, which can be a major handicap. It requires a major amount of discipline to reflect, come up with improvements and test it out at the next cycle. If a person spends many years without going through all this, the level of incremental improvement will be far less. But if one does think through and reflect upon changes, then he is actually very valuable to us.

Thoughts on medical education

TYS: What do you think of the residency programme?

PC: The way I look at it, there was very little structure or formal training under the old style that I was trained in. It was essentially survival of the fittest and very few managed to get through in each cohort. In a way, the programme did not allow for many of us to be developed properly or to remain in the system.

Under the residency programme, we are trying to make it easier. In the old system, if someone is very good, he will get through but if he is average, he will struggle to survive. What we've done in residency is to allow the majority of people to get through. This is done via structured training programmes, which reduce the variations in outcome. This is good, though a lot more resources are now required. I feel that the speed at which it is done is appropriate, and that we are on the right track.

TYS: Do you foresee the third medical school eating further into the resource pool available, in terms of teaching and patient load?

PC: We don't have enough. We need to build up our base. If we do not invest initially, we'll never have the desired outcome. We have increased our overseas recruitment but the variation in quality is great. The departments are highly stressed in overseeing and trying to bring everybody up to a certain acceptable standard. This places a strain on the system. If we can train between 70% and 80%, minimal standards of performance would be ensured.

All three universities from Singapore have a certain standard and are not too far off from one another. When someone does something well, the natural tendency is for other parties to follow suit. To me, that's good because we compete on value and outcome. The three are very close; we are recruiting from the same base of people. We will produce doctors with fairly minimal variation and that will reduce the stress on clinical departments. I think this is something we have to go through, and we can do it in such a way where it is still manageable but knowing at the end of the day, it will solve a fair bit of our problems.

Concluding thoughts

TYS: What is your favourite cake?

PC: My favourite cake is currently Twelve Cupcakes from United Square. Another favourite is macarons from ET Artisan Sweets or Antoinette. I also like the ones from Canele.

TYS: What is one thing nobody knows about you?

PC: I like art and paintings, and I collect them. Some are by local artists and some from Vietnam.

TYS: What keeps you awake at night?

PC: It depends very much on the issues of the day. Most times, it's just my habit of reading. I read voraciously, and will download items from the Internet. This allows me to update myself on what is going on. I also try to come up with solutions to problems that we face. Drinking coffee and watching silly shows keep me awake too. (*laughs*) But now I watch documentaries to unwind and not think of work. I enjoy documentaries.

TYS: How would you like to be remembered?

PC: Actually, I've never really thought about that. I remember the teachings of people who mentored me and one of them is not getting attached to unimportant things. These things include your position in your institution, or the perks of one's jobs. Institutions like TTSH have existed longer than Singapore. We serve our time in an organisation and what is important is that you have made improvements during your shift and added to the culture. Beyond that, I have no aspiration of being remembered. SMA