

# WHAT CAN A DOCTOR LEARN FROM PUBLIC POLICY SCHOOL?

Text and photos by Dr Christopher Lien

have just returned from a year in New England, doing what many generations of doctors before me would have done – spending a year abroad in pursuit of further training. With my wife and young children in tow, we set up a home away from home, and experienced America – the dramatic seasons, the exciting outdoors, and the ultimate Singaporean release: outlet shopping!

### Making the unconventional decision

Fuelled by such guttural instincts, we arrived in Cambridge, Massachusetts, comfortably surrounded by doctors on the Healthcare Manpower Development Plan and many Singaporean students studying in the Boston area. What made it unusual was perhaps my decision to pursue a master's degree in Public Administration. I was not a policymaker, and had no political ambitions, clout or talent. I was not famous, nor was I ever hoping to be. I was just a decrepit, ageing hospital consultant in one of the most unpopular specialties in Singapore – Geriatric Medicine, where people think our training helps us to be nice to old people.

The knowing looks from colleagues seemed to confirm how naive I must have seemed. To be honest, I was struggling with seeing old people being tied up just to be kept alive, the distress and pain that patients and their families faced from disabilities, and the burden of caregiving. Our ability to rehabilitate and prevent disability is rudimentary, compared to our stellar ability to keep people alive. I badly needed a break.

### **Embarking on a new journey**

The Harvard Kennedy School (HKS) of Government offered ample opportunities to interact with many people from the developing world and beyond. Our country may not have abject poverty, but we have a high income disparity. Many families whom we encounter in public hospitals live in two- or three-room flats, and have significant subsistence difficulties, which remind us of the extent of social segregation there can be in Singapore. Our exceptional airport, the gateway for many high net worth individuals, is something many of my patients will never experience personally.

Moral hazards, fear of supplier-induced demand, incentives, nudges and mechanisms that prevent market failures illustrate the landscape of patchwork policymaking and dissonant value systems. Singapore policymakers are certainly well versed in such a lexicon, and not surprisingly, many professors from HKS like to use Singapore case studies to illustrate successful policy interventions.

As a student, I could choose four to five classes each semester from the hundreds of courses offered. This buffet of opportunities encouraged me to read widely, think deeply and be persistently curious. My schoolmates' diverse cultural and professional backgrounds fuelled rich and engaging conversations, debates and disagreements along corridors, in student groups, informally at picnics, or even just over beers. Speakers from around the world would visit the school, inspiring students to a greater purpose, and to have faith in efforts to build public institutions.



Dr Lien with his young son after a Harvard-Yale game

I took a class on nonprofit management at the Business School and in the process, had a taste of the slick classroom dynamics in a school known for innovative profit maximisation. Unable to escape from my healthcare heritage, I cross-registered at the School of Public Health to study with two exceptional health economists. However, it was the Kennedy School that affirmed my belief that it is not mad to be serious about alleviating suffering and poverty. Asking the right questions is invariably more important than being too hungry for technical quick fixes, especially when the nature of the problem (and hence, the solution) is not terribly clear. Learning to fail is an oxymoron, but yet so critical if we want to make effective interventions on real issues.

NIMBY sentiments are not unique to Singapore. What perspectives are we missing in the complex systems that we are all part of? How can we trust our people more (and not be too obsessed about making people trust the whole of government)? How can we learn the value of participatory decision making, so that we can facilitate creative solutions from the people whose lives are directly affected by our policy dilemmas? How can we listen more effectively? Who do we listen to and what do we listen for? How do we identify shared and opposed interests, and the competing values at stake? There are really no correct answers to these series of questions. Having the courage to ask them is the greater challenge, and what is clear to me is that we must stop thinking that anger from the ground can be effectively addressed simply by ensuring better communication from government agencies.

## **Enjoying family time in Boston**

My family and I had a great year away in Boston. Our four-year-old son loved the nursery cooperative he went to: school was filled with new discoveries and fun things to play with every day. We enjoyed the museums, libraries, parks, playgrounds, beaches and nature reserves. Given



the heavy course work, I was a very distracted spouse and became highly dependent on my wife, without whom I would not have survived the year. We learned something very precious about being a family. We had no live-in help, so we had to be involved in the daily needs of our children — their meals, bath times, bedtime stories, or just waking up as a family. We certainly did not experience these intimate moments with such consistency in Singapore.

# **Coming home**

I have since returned home with the conviction that as doctors, we are particularly called to serve. Many of my closest friends in Medicine are now in private practice and, without exception, have become renewed by the autonomy they now have to practice the values they aspired to in medical school. This is a very useful data point for the Ministry of Health to consider. In the process of building our so-called medical excellence, we have also cultivated a system of mediocrity and complacency that is full of waste and contradictions. Asking patients to exercise their preferences when there is so much information asymmetry seems to be consistent with the way we design policies to prevent overuse when there is such gross underprovision of essential services. As doctors, we have become disillusioned that our public healthcare system genuinely cares about public service.

Recently, I have been covering a facility full of bed blockers consigned to a sleepy off-site ward rented by our hospital. Surprisingly, I have had a really inspiring time. The ward's resident physician, social workers, nurses and therapists have pulled together to try to make a genuine difference. Patients, who were given up for their lack of rehabilitation potential, are getting out of bed, being taken off their diapers, walking and becoming less dependent. Nursing home admissions are being averted, and families can hardly believe that their loved ones are now functionally better than when they were first admitted to hospital many months ago. Precisely because discharge plans are still unclear, there is no rush, and time for meaningful rehabilitation becomes a positive externality. This must be what confronted Marjory Warren at the West Middlesex Hospital in London in 1935, where the practice of contemporary Geriatric Medicine was born.

I have been refreshed and recharged by my one-year sabbatical. There is much to do, and many willing partners and allies, both in Government and civil society. I guess we are building and improving the healthcare infrastructure for ourselves when we too get old.



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