2012

Purging Healthcare of Conventional "Wisdom" - An interview with Liak Teng Lit

Lien Centre for Social Innovation

perspectives

PURGING HEALTHCARE OF CONVENTIONAL "WISDOM"

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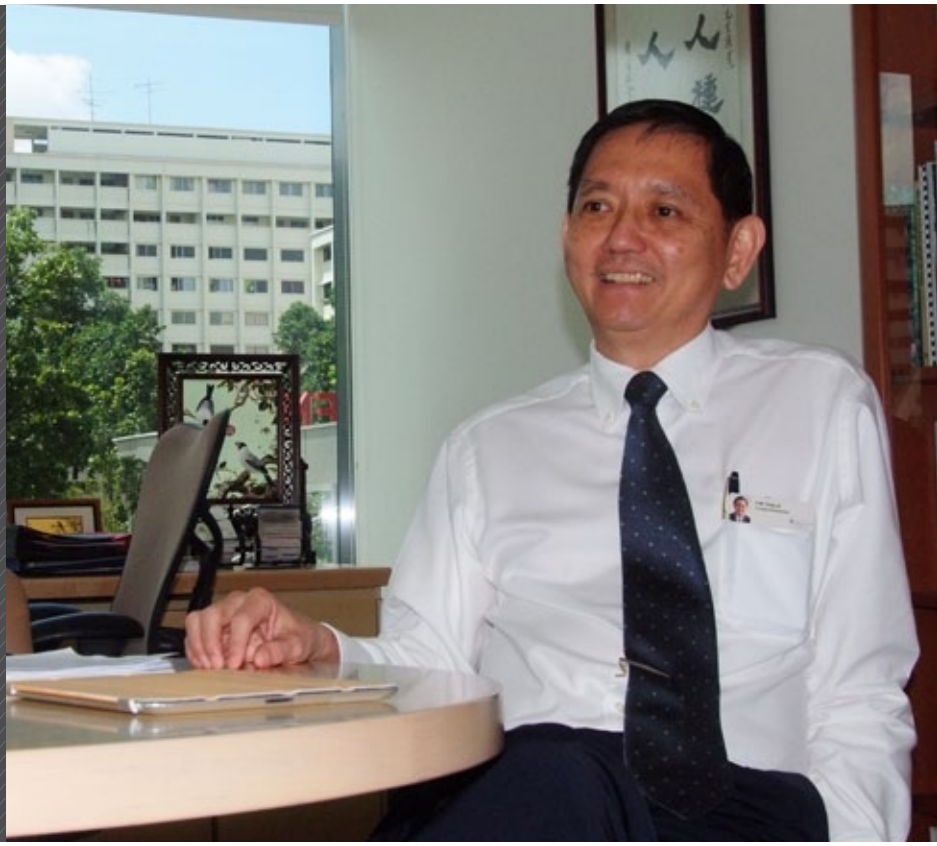

Liak Teng Lit is known for his iconoclastic views and for pushing the envelope on healthcare and other social causes. Social Space visits the maverick in his award-winning Khoo Teck Puat Hospital for some wake-up calls.

Liak Teng Lit is the Group CEO of Alexandra Health and Khoo Teck Puat Hospital. He has been in the healthcare industry for 35 years. A pharmacist by training, he was involved in the restructuring of major hospitals in Singapore. Liak serves on the board of several non-profit organisations and government bodies including NTUC Healthcare, NTUC First Campus, Community Chest, NorthLight School and Pathlight School. He chairs the Water Networks, Public Hygiene Council of the Ministry of the Environment and Water Resources and the Healthy Lifestyle Functional Committee of South West Community Development Council.

Social Space (SS): This is a simple office you have here in this impressive building that has become the icon of innovative healthcare in Singapore.

Liak Teng Lit (LTL): Well, this building is new; it is only two years old. In five years' time, when age takes its toll, this building will be just like any other old hospital.

In any case, healthcare does not happen here in this building. Hospitals are about illness care. Healthcare takes place out there [pointing to the block of Housing Development Board (HDB) flats outside his office window]. That's why at the Khoo Teck Puat Hospital, we make sure that our work, our facilities and our people are integrated with those in the community.

Those 4-room HDB flats are a good reminder to me about the real work that needs to be done. It is a conventional stupidity that more hospitals and more hospital beds result in a healthier population. It is the very opposite: The healthier is the population, the less the need for hospitals. By the time you come to the hospital, it means you are no longer healthy, and often it is too late.

SS: Sounds like you don't want to have too many patients.

LTL: Don't get me wrong. We are not trying to work less hard by asking for fewer patients. We only want the best for them.

In the healthcare industry, we tell our friends we don't wish to see them back again for a

long time. We tell our enemies we wish to see them again, real soon. We don't have too many enemies.

SS: Apart from enemies or friends, how often do you want patients to be treated in the hospital?

LTL: To answer that, let me share with you the example of Teng Jong, my late sister who died of cancer at the age of 56 years. She led a healthy and robust life until she was diagnosed in 2008. Since the cancer was at an advanced stage, she decided that palliative care was the best option rather than further treatment. In fact, we asked the liver surgeon: "If this was your own sister, what would your advice be?" His answer was pain control and palliative care. The family supported her decision.

In the last few days of her life, my sister's breathing was laboured and she was bedridden. The family gathered around to provide emotional support. The peace and willingness with which we let her go had a pleasant outcome. She breathed her last after three days on a Sunday, surrounded by all of us. She did not lead a wasted life, and she left surrounded with love. We couldn't ask for anything more.

SS: By not treating a patient, are we not hastening death?

LTL: Palliative care doesn't mean we are hastening death. Contrary to what many people think, palliative care often requires aggressive treatment to reduce pain and discomfort and help the patient maintain his mental and physical functions. In surveys of patients with terminal illness, their more important priorities include avoiding suffering, being with their families and not being a burden to others. Ironically, many studies are now showing that terminally ill patients who opted for palliative care, actually lived longer than those who opted for aggressive curative treatment.

SS: What are your views on euthanasia?

LTL: Euthanasia is illegal in Singapore. Some people have a crystal clear view, a very black and white interpretation: that to help another person end his life is the same as murder. I am not so sure. Most of us would agree that we should not encourage or help a person to commit suicide.

But what if the person is terminally ill, is in severe pain and discomfort, and has absolutely no hope of living beyond a few days or weeks? What if he is begging for a very high potentially fatal, dose of painkiller? What if he is also unable to eat, drink or breathe on his own and he is only alive because he is hooked to the ventilators and fed through intravenous tubes? What if he is begging for the machines to be turned off and let him die?

What would you want if you were in his position? This issue gets even greyer in the case of severe dementia.

With technology, the heart can be kept pumping even when the brain is not working. We call this mental death. Would you want to live this way, and would you want to be remembered this way?

I, myself, have left very specific instructions for friends and family: The day when I can never go to the toilet on my own or be useful any more, I would not want any form of artificial interference such as IV feeding, tube feeding, or even oral antibiotics, to be administered. That is a choice I have made for myself.

It is a hard decision that family members must sometimes make for their loved ones when no such instructions are left.

For me, I have gone to more places, planted more trees, and climbed more mountains than I need to. I am happy to go when the time comes.

SS: Is this conventional thinking for medical professionals?

LTL: I refer you to a poignant article, "How Doctors Choose To Die" which was published recently in the Guardian newspaper in the UK. It was written by a doctor. He cited the example of his mentor, a respected orthopedist who, after being diagnosed with pancreatic cancer, closed his practice and never stepped into a hospital again, choosing, instead, to die at home surrounded by his loved ones.

The moral of the story is not about giving up. Rather, it is about understanding the limits of doctors and science and to put more faith in dying peacefully and without the need for exorbitant medical costs. Many doctors choose this path because they understand this fact more than the common man.

Many patients and their families are usually too engrossed with averting the guilt of not being able to save themselves or their loved ones. So, they ask for more and more treatment, to extend the life of themselves or their loved ones, but to what avail? By another day, another month?

It is about understanding the limits of doctors and science and to put more faith in dying peacefully and without the need for exorbitant medical costs.

> It's a biological fact that we will eventually die. To fight death at all costs, results in overtreatment. Such treatment is a conventional stupidity.

SS: Leaving the patient to die peacefully is a passive act. But to consciously withhold treatment or to go further and actively induce death would be playing God, would it not be?

LTL: Well, guess what? Every day when we come to work, we are playing God. When we make a decision to expand the ICU facilities, we are playing God. When we administer vaccination to artificially protect the human body against the chances of contracting a disease, we are playing God.

Modern medicine is interfering with God's work. That is a good thing most of the time when we prevent unnecessary illness, relieve pain and save lives. Unfortunately, when a patient is terminally ill and is dying, society still keeps asking us to play God, to make one intervention after another. Often these interventions are futile and lead only to more suffering and pain for the patient.

In fact, some geriatricians say that pneumonia is a good way to go for the elderly. Our lungs get flooded and our oxygen runs low and before you know it, you have drifted off to die, like an anesthetic effect.

SS: You are running a hospital. Wouldn't your patients get worried about such statements?

LTL: Again, don't get me wrong. We are not just about palliative care; our services span a much broader spectrum. Here, we are an acute care hospital. We do our best to help patients tide over their conditions quickly and comfortably. We help people lead long, healthy lives and importantly, we make sure patients receive thoughtful dignified care towards the end. Take a look at our ICU wards; you don't see gloomy rooms as if we are preparing the patients for their pending end.

A friend of mine passed away recently at 80. In his dying days, his kidneys were gone and we couldn't find the veins to insert the tube in. We couldn't do anything more but the doctors tried very hard to keep him alive because his daughter in London was making her way back to see him. We managed to keep him alive long enough for his daughter to arrive. She held his hands during his dying hours. So even when we can't, we do try.

Let me come back to the question on how doctors think. Three years ago, I was with over two hundred doctors and healthcare professionals in the hospital auditorium discussing a patient case study. This patient, a 78-year old was a long-term diabetic, one foot was already amputated. He was brought into the hospital by ambulance in a comatose state with the other foot gangrenous. He was a long-time resident at a nursing home, demented and was all alone with no family members to give their consent.

The discussion was whether we should proceed with surgery without his consent. We took a vote and two-thirds of the room voted for surgery. After all, doctors are under oath to save lives, regardless of the circumstances.

Then we asked the question differently: "If you were the patient and could make a decision, what would your choice be?" This time, only two voted for surgery, with over two hundred voting against it.

My point is that the healthcare system is routinely doing things for and to our patients that we would not want others to do for us if we were the patients.

It's a biological fact that we will eventually die. To fight death at all costs, results in overtreatment. Such treatment is a conventional stupidity.

SS: What exactly do you mean by "conventional stupidity?"

LTL: It's when conventional wisdom turns out to be stupid. For many years, we may have thought that we are doing the right thing, only to realise years later, that we have actually been doing the wrong thing. Sometimes it was the right thing to do but over time the context has changed.

Remember the early days of the welfare state, when the term sounded good and many jumped on the bandwagon. The Beveridge Report got the ball rolling after World War 2 in the UK. It was supposed to be a cheap and efficient scheme where the state help a small group of the really poor receive adequate income, employment, education, healthcare and housing. Except that once the state started giving, it couldn't stop. In a one-man-one-vote system, political parties usually find it's a vote-winner to promise to give even more. They conveniently forget that the bill has to be paid, if not now, then in the future.

Eventually, welfare expanded to become an entitlement for virtually everyone. Now, welfare spending is significantly greater than the entire education, defense and transport

budgets combined in the UK. UK and many other countries are now waking up to the problems of the welfare state.

SS: Apart from overtreatments, what other conventional stupidities are there in healthcare?

LTL: Subsidies, for one. Numerous examples show that the moment subsidies come into play, the demand for the service increases, and this leads to more shortages and unintended outcomes.

Iran produces oil, Iran subsidises petrol, Iran runs out of oil. Indonesia produces gas and oil, Indonesia subsidises gas and oil. They now spend over 20% of the national budget on fuel subsidy. They just had riots on the street when their governments tried to reduce the subsidy.

We do need to remember Economics 101: Lower the cost (artificially through subsidy) and demand goes up.

SS: How do subsidies play out in healthcare?

LTL: Say you have an 85-year old grandmother who has become better after treatment in the hospital and is ready to be taken home. I would not be surprised if you continue with hospital care instead of taking her home if there is a heavy subsidy. Why? Because you have nurses looking after your grandmother around the clock and you only need to pay a small fraction of the cost.

Well, if each patient stays just another half a day, we would need another Singapore General Hospital. That is S$2 billion to build and about S$0.5 billion subsidies to run annually. But that would also mean that the government would soon need to increase the Goods and Services Tax, say, to 20% to cover the cost of these additional beds.

We are now at the verge of genomics or personalised medicine. Diseases are increasingly going to be diagnosed at the genetic level. Effective but very expensive treatment will be invented to treat diseases. If we want to live to a hundred years old and beyond, we are each going to need a million or more treatments. Few of us can afford it, so who will subsidise if not government? Unfortunately, there is no free lunch. If we each need a million dollars in subsidies, we will each have to pay a million dollars in taxes.

SS: How about medical insurance?

LTL: Well, we need to understand how insurance works in the first place. It works when there are rare occurrences and big payouts, like when your house is on fire.

But healthcare is the opposite. If my medical cost is covered by insurance, at the margin, which option will I want; the cheap option or the expensive option—the Toyota or the Lexus? I can tell you that everyone at the margin will opt and push for the Lexus.

Numerous examples show that the moment subsidies come into play, the demand for the service increases, and this leads to more shortages and unintended outcomes.

Since the provider will make more money selling the Lexus than the Toyota, he will also make the Lexus more available than the Toyota. You just need to look at what is happening in the US. They are now spending about 18% of their GDP on healthcare, but getting outcomes worse than others who spend a lot less.

If insurance companies pay for our food, everyone will want to eat gourmet. It's the same with healthcare.

SS: So what is your answer to the call for more subsidies—zero subsidy?

LTL: Not at all, but we need to be aware that there is a limit to subsidies, because there is a limit to supply. Once we have over-demand, we need a bureaucracy to control and channel the demand. The whole bureaucracy costs money.

Our current healthcare financing, the 3 Ms (Medisave, Medishield and Medifund), is a sound way to go. All of us are going to need a certain amount of treatment. And you have to decide what amount of your resources is going towards healthcare needs. And we have to do it in a way that doesn't bankrupt the next generation.

Mine is not going to be a lot because I will go the way my late sister did, through palliative care.

Is our health really that expensive to upkeep or is it about our personal choices? For the majority of us, it is the way we live our life. As long as we do not over-eat, exercise regularly, do not drink too much or smoke and maintain our hygiene, we should be fine. The first two are very important; once you become obese, the chances of you suffering from diabetes, knee pain, kidney failure and heart conditions are higher. It's not just about the aesthetics.

I would argue that a real doctor is like the internal medicine physician, geriatrician or paediatrician of the old days. It is akin to that of a kungfu master who spends many years getting the basics right.

SS: Was that why you require your staff to have a healthy BMI as part of their personnel evaluation. You got quite a bit of heat for it, didn't you?

LTL: Yes, we do want our staff to be healthy. It's not just because it is good for them; it is also because we need to walk the talk as health professionals.

How can you have a healthcare professional who is obese advising you to cut down on your food intake? Before one spreads the message of a healthy lifestyle, one must first internalise it.

As hospitals, we need to go beyond illness treatment to health advocacy. And to advocate, we need to live the message. Health is really about personal choices.

Yes, I came under fire for the policy, but I refused to withdraw the policy or apologise. There is an elephant in the room, but many choose not to see it.

SS: Are there any other notions that many doctors have that are not quite right?

LTL: Well, the specialist tracks that doctors are taking very early in their career would be one.

With knowledge expanding so fast, there is a widely accepted view that doctors need to specialise or sub-specialise as early as possible. So, an eye specialist looks after the eye and the cardiologist looks after the heart.

However, it's gone even further. Each area of the body is now further subdivided. So you have one eye specialist who looks after the retina while another looks after the tear duct. And each cardiologist looks after only one square centimetre of the heart.

However, a patient usually comes in with a whole host of related issues. Since each specialist does not bother with other parts of the body outside his scope and since they generally do not even talk to each other, much less decide with each other about the patient's condition, the patient is not truly taken care of as a whole.

I once attended a medical conference where I sat between two specialists, both professors. Another specialist was presenting and I did not understand the term he was using. I turned to the specialist on my right and asked him if he knew what the presenter was talking about. He said he did not know. So I turned to my left and asked the same question, and the other specialist did not know either. That's how specialised and narrow we have become.

The conventional wisdom is that development in science and technology is so rapid that we need to specialise and sub-specialise in order to keep up. But this has turned our doctors into technicians—technicians of a very small part of the human body.

SS: So you believe that doctors should be generalists instead of specialists?

LTL: I would argue that a real doctor is like the internal medicine physician, geriatrician or pediatrician of the old days.

It is akin to that of a kung fu master who spends many years getting the basics right. These are the doctors who put in the initial ten years or more of solid hard work doing a lot of things. Their career progress, in the initial years, seem flat but they develop a deep understanding of the human body as a whole and they become excellent specialists later.

My colleague Professor Rajasoorya said it well when he recommended doctors that they should first be a good doctor, then a good specialist and only after that, a good sub-specialist.

SS: Any other conventional stupidities in healthcare?

LTL: Economies of scale, that big is beautiful.

Some people seem to believe that everything should be big, consolidated and centralised. But I am not sure if it should always be the case.

One Dilbert cartoon depicted it best when it said that we appear to be a visionary planner when we decentralise everything which is centralised in one year and then we

centralise everything which is decentralised in the next year. The consultant makes lots of money, the CEO says he is working hard, but essentially, we go back to doing what was done before.

SS: Should healthcare organisations be centralised or decentralised?

LTL: Certain things need to be centralised, others decentralised. Swinging from one extreme to another doesn't work. Depending on what we are trying to do, there is a need to organise ourselves in a way that is appropriate to the context we are in and not blindly go one way or another.

For example, if we go into patients' homes, their needs are so varied and family support is very diverse; there cannot be a one size fits all. Yet, when we talk about intervention, we are usually so structured in our approach that it actually does not always reflect the reality on the ground.

In my personal opinion, there needs to be multiple layers of services cross-cutting these different settings and led by different organisations and cross-sector individuals.

As a first layer for example, we would like the social arrangement to be mutual, rather than one that is arranged and over-professionalised. This layer creates an environment that is flexible and enabling. Perhaps it can be the neighbour-looking-after-neighbour system and where the rooms in the HDB flats can be retrofitted such that the patients can function during those times that they are alone.

The next layer goes one level up, where the needs are different and more intense and which require the services of a small group of professionals who can handle a crisis situation and provide a fast response.

It's like going back to the kampung days. I imagine, on a typical day when the elderly go to the market, they will stop by the nurse's station in their neighbourhood and ask for advice or simple prescriptions such as panadol or cream. As for the neighbour who looks after another neighbour, he or she will not be doing it for free. We can find a way to pay them, say $500 a month as long as they go out and look after three other elderly persons each. And if they fall sick and in turn need care, then they will be paying a fee. There is potential here to create a cooperative.

The models are evolving to respond to the changing textures of society. By 2030, one in five persons in Singapore will be above 65 and one in ten will be over 80.

In these times of globalisation, all the more there is a need for kampung-isation, where people take care of each other and where they can relate to one another in the neighbourhood.

SS: Khoo Teck Puat Hospital has won a number of awards: The President's Design Award 2011, the BCA Green Leadership Award, and recently, the FutureGov-Healthcare Organisation of The Year. It also topped patient satisfaction surveys. Innovation has been your hallmark. Would you like to share with us how you and your staff come up these innovative ideas?

LTL: I go by this philosophy: Learn from everyone, follow no one, look for patterns and work like hell.

Service is about people, flow and touchpoints. On flow, we learned from Toyota. On touch points, we learned from Ritz-Carlton and Singapore Airlines.

I think it is important to recognise that there is no magic bullet. The innovative process is never sequential. Often, we tried many things to create something wonderful or to solve a problem. Most efforts end in failures. But along the way, we will uncover some things that work. We just keep trying.

For innovation to happen, key performance indicators, or KPIs, don't work. KPIs are there for the staff to maintain the minimum standards to keep things going—it cannot motivate people to perform. At the end of the day, it's about the obsession to make it work, even down to the minutest detail.

It is also important to note the organisational inertia in making change happen. So part of it is getting people motivated to change and move.

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SS: You are involved in non-profit work beyond healthcare. Based on your broad experiences, what kind of society are we becoming and what should we be working towards?

LTL: We should work towards a society that is aware of not only its rights, but also its responsibilities. We can see that Singaporeans are now going through an awakening and would like to have their voices heard. But we don't want to end up with a society of howling monkeys where we scream, shout and jump up and down breaking the branches and end up hurting others. We need to establish some ground rules and abide by it. Those who don't, can choose to live on an island of their own.

It's all about exercising personal leadership over our lives.

If you ask me, as individuals, we should put in a little bit more than what we get from society.

SS: How can we go about doing that? Should the government lead the way?

LTL: I would say change starts with the individual and his or her immediate sphere of influence, such as parents. It should not be the government.

My observation is that there are generally three groups of people: The good, the bad and the ugly. Take littering as an example. The good, those who will not litter, make up 60 plus percent of the population. The bad, those who litter occasionally but can be corrected, are about 30 plus percent. One to two percent are the ugly ones, the sociopaths who have no care for rules and will litter no matter what you do.

If we want to have a clean and beautiful Singapore, the 60 plus percent who are good should take charge and stand up for the right behaviour. So, if I see someone littering, I would stop that person and say, "Excuse me, sir, can you please throw the litter in the bin?" Most of the time, the people I speak to would pick it up, but some will ignore me. Five percent will scold me, and when they do, I pick the litter up, throw it into the bin and walk on.

For the truly ugly, the sociopaths, we should have strict laws and throw the full weight of the law on them.

We live in a densely populated community. All the more we need simple rules of engagement. The main issue here is to be considerate to one another.