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SMA NEWS

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INTERVIEW WITH PROF ABU RAUFF

by Dr Toh Han Chong, Editor

Prof Abu Rauff obtained his MBBS in Calcutta in 1962, and subsequently completed his M.Med in Delhi. He later underwent subspecialty training in the UK. From 1985 to 1988, Prof Rauff took up the chair of Surgery at the Singapore General Hospital, and later at the National University Hospital from 1988 to 1992. On 29 September 1990, Prof Abu Rauff participated in Singapore's first liver transplant at the National University Hospital. He was also teacher to many of the top surgeons in practice today. Prof Rauff later left for private practice but dedicates three days a week teaching clinical surgery to undergraduates and postgraduates, as well as participating in research projects at the National University Hospital.

Prof Rauff is currently Senior Visiting Consultant at the Department of Surgery in the National University Hospital, Visiting Consultant specialising in vascular surgery at Changi General Hospital, and Honorary Visiting Consultant at Dover Park Hospice. He is also Advisor at the Minimally Invasive Surgical Centre and a member of the Singapore Society of Oncology.

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THC: What were your experiences in Surgery as a Registrar?

AR: My surgical career has developed in three phases – in India, in the UK and in Singapore. I did my undergraduate studies and early post-graduate training with a Masters Degrees in Calcutta and Delhi. In the UK, I underwent subspecialty training. I was in the UK for quite a few years doing vascular, cardiac and general surgery. In those days, one would not stay put in a single location in the UK – one would be eyed with great suspicion if you did not move around. I did vascular surgery in Essex, cardiac surgery in Manchester and general surgery in London, Liverpool/Chester and North Wales.

I was fortunate to obtain good subspecialty training positions. In those days, the major surgical specialty groups were Plastics, Paediatics, Neurosurgery, Cardiac, Orthopaedics and Urology. General Surgery sub-specialties were not yet well-defined. When I came to Singapore, Urology was not a yet a separate entity – there was only Orthopaedics and Surgery. This was in 1972 and Cardiac had just taken off while Plastics was at its initial stages; paediatric surgery as we know it today had not been identified as a specialty.

In those days, surgical training was either in general surgery, cardiac surgery or orthopaedics. Slowly, there was a branching out into identifiable sub-specialties. I was fortunate to have very good mentors at each phase of my career; people who instilled excellent values and were role models. Back in India, I worked with two of the most famous Indian surgeons, S K Sen and K C Mahajan. Prof Sen passed away a few years ago and last year there was a monograph and a presentation to commemorate him in Delhi. He was one of the pioneers in the Indian surgical field after the British left. Dr K C Mahajan, although being 82 this year, is still actively teaching in a big private hospital in Delhi.

In the UK, my mentors were those who imparted surgical skills and clinical knowledge, rather than life values. The vascular surgeon, Dr Raymond Sutton, came to stay with us a few years ago – he was going around the world to visit all the registrars he had taught over the years. One day, he called me up from the UK and announced his plans, asking if he could come by for a visit; he had my contact as I write to him every year at Christmas. His surgical technique was excellent. There was also a senior cardiac surgeon in Manchester, Dr John Dark. He was one of the best surgeons I've ever worked from in terms of technique and attitude – I learnt a lot from him.

> Which surgeon does not think of himself as the best? Imagine running a group of people who all think like this; and trying to obtain and maintain a cohesive department. It is a lot of hard work.

When I came to Singapore, Dr NK Yong had already left and Dr K T Chan was in private practice. Dr Ong Siew Chey, then Professor and Head of Surgery A, taught us a lot about clinical evaluation, patient care and surgical discipline. Without this, one cannot do good surgery. You may be the greatest technician in the world but if you cannot take care of patient; you will not be able to help him or her at all. Prof Ong set high standards for us to follow.

I had great respect for Dr Yahya Cohen and Prof Raj Mohan Nambiar, who was four to five years my senior. There was some friction between the surgical units at that time, but I seem to have gotten along well with the "B" unit surgeons! These were people whom I looked up to and learnt from.

THC: As a medical student, did you already know that you wanted to be a surgeon?

AR: I always wanted to be a cardiac surgeon but circumstances were such that it was not to be. I have certainly had a very fulfilling general surgical career. I enjoyed working with my hands, and later appreciated the fast decision-making process that is necessary in surgery, as well as being able to see immediate results of one's efforts. As a young person, the excitement of performing surgery was enough to make one forget the hard work and long hours.

THC: As a Professor at the National University Hospital (NUH), what are your fondest memories of the university?

AR: I still go back to NUH thrice a week. The reason I do this is because I feel passionate about how much young talent we are losing to private medicine. This is not restricted only to the surgical field, but in medicine on a whole. Young people who have obtained their HMDP and with special skills leave for private sector medical practice early. I feel that there should be a mechanism whereby we can still tap this talent into public service. We should still be able to use them in public hospitals even after they have left, and this is what I have been trying to demonstrate in the last twenty years – I dedicate two whole days to the university each week teaching undergraduates and postgraduates, doing clinical and operating sessions. It may seem like a lot of time sacrificed but I don't mind it because it is enjoyable. I also learn a lot from the young people and I hope that my efforts are beneficial to the students, doctors and the departments.

THC: Will this give rise to the mindset that one can leave for private practice and wait to be invited back, so as to have the best of both worlds?

AR: I don't think so. In the public hospitals, there are surgeons who are highly specialised. To a young person who has left for private practice, he can still contribute to his specialty. My contribution to NUH is through a group of endocrine surgeons at NUH. This group has developed nicely over the years. Highly-specialised private surgeons should be able to contribute their special knowledge to the in house specialty groups.

I feel that those who leave as specialists should be invited back to contribute to the specialty groups with specialist activity in the institutions. They should not be asked to do routine clinical activities. The amount of time spent depends on the individual. The specialist can embark on clinical, research or teaching projects in that specialty. Most of those who have left would like to contribute but those who are still "in house" must accept them and utilise their specific skills and strengths.

THC: How do you think we can create an environment in academics to attract these specialists back?

AR: Most of these young people who have left would like to be invited back, and those "in house" must firstly want these specialists as they may positively contribute to the development of the specialty. To my mind, there are three conditions that have to be met: the department and specialty group must firstly recognise and need the expertise of the individual, the specialist must be willing to sacrifice a certain amount of time, and lastly, in today's context, the specialist must be remunerated to acknowledge the contribution made. Without these, I do not see why those who have left would return. Of course, there must be a sincere commitment to fulfill one's obligations on both sides.

THC: When you left for private practice, many felt that a big hole was left in the department. Why did you not stay?

AR: Running a department is mentally and physically exhausting! Which surgeon does not think of himself as the best? Imagine running a group of people who all think like this; and trying to obtain and maintain a cohesive department. It is a lot of hard work. Secondly, it is difficult to maintain respect from your peers and colleagues, if there is laxity in discipline or there is bias unknowingly. It is a lonely job.

I left because of the administrative load. I had to spend more time in the university senate, hospital board and inter-hospital meetings than with my patients and students. It affected me mentally and physically. I got so depressed that my wife, Mary, insisted that I do something about it. This was a pity because as a department, we were getting along quite well, and I enjoyed what I was doing. Teaching surgery and being stimulated by young minds and one's peers is very fulfilling.

THC: Do you think Professors of Surgery in overseas institutions like Cambridge or the Massachusetts General Hospital face the same administrative hassle?

AR: Overseas institutions tend to have many more coordinators and support staff. They have more support in the form of administrative staff and public relations because they are also responsible for a lot of fund raising and public relations! Most Chairmen are also given full control of their departments.

THC: What were the challenges in academic surgery in Singapore?

AR: When I took over as Head of Department, there were no sub-divisions in Singapore's general surgery. There was no identifiable specialties outside orthopaedics, cardiac and neurosurgery. The first thing I thought we should have was sub-specialisation development; I did not feel that we could progress without subspecialties. In Prof Foong's era, surgeons would do everything from plastics to urology! By 1992, Urology became established as a speciality and credit goes to Prof Foo Keong Tatt – we were lecturers at the university together. He is a good man, a surgeon philosopher and role model. He really pushed for Urology to become recognised as a sub-specialty, in spite of the difficulties he faced.

Within general surgery, five subdivisions were established – gastrointestinal surgery (colorectal and upper gastrointestinal), hepato-biliary pancreatic, breast and endocrine and lastly, vascular and trauma. Vascular surgery was then performed by cardiac and general surgeons. Cardiac surgeons did not want to work on varicose veins; they wanted to focus on aortic

aneurysms. Today, all hospitals have identifiable vascular surgery and these surgeons remain general surgery-trained but may become a specialist on his own.

Personally, I feel that the Europeans have done the right thing – those in the general surgery group are called 'abdominal visceral surgeons'. These surgeons are trained in all types of abdominal surgery and as they get more senior, they tend to focus on certain aspects of abdominal surgery, like upper or lower gastrointestinal surgery and so on. I feel that training in abdominal surgery should be a standard for general surgery.

THC: What is your opinion of the American's practice of super-specialising?

AR: Even in America, from looking at their surgical departments, it looks as if their surgeons have special interests within their department of general surgery. The Mayo Clinic and endocrine surgeons came over about six months ago, and one commented that he had just completed a gastroectomy before he left for Singapore. This was an endocrine surgeon performing gastric procedures and even does emergency calls! So, he is still a general abdominal surgeon.

THC: Is there such a thing as a general surgeon today?

AR: The lay person (medical/non-medical) would think that a general surgeon does a little bit of everything, but in reality, the training still centers primarily on abdominal surgery. Perhaps our general surgeons should also be known as abdominal (visceral) surgeons. Given that the abdominal anatomy is so close to each other, you cannot avoid overlap. An abdominal surgeon can perform aneurysm repair if he has had vascular training but a vascular surgeon will also do endovascular therapy today. This applies to other general surgical subspecialties.

THC: What are your thoughts on the possibility of introducing a residency programme into specialist training?

AR: The American residency programme is similar to the Advanced Surgical Training (AST) and Basic Surgical Training (BST) that we have here. Without taking into consideration the FRCS/M. Med Examination, it is almost the same. The only difference is that we do not have the important yearly in-house assessments; perhaps we should emulate this. Our BST programme spans three years, where we try to be seamless. Trainees have to show their competency in basic science and clinical knowledge, similar to the residency programme. We can improve our programme by introducing regular assessments and mentor supervision more effectively.

One should not merely rely on degrees, but rather the time spent on honing one's skills. At the end of five years, one becomes a surgical specialist after being certified by the Medical Council. For the four-year American residency programme, I find that the surgeon or physician is at the level of our Senior Registrars. In the US, doctors have to join practices once the residency programme ends – they cannot join another residency. However, when these doctors find that they want additional specialist training, they join specialty fellowship programmes. Almost all residency programmes now have a fellowship component, which provides two years of in-depth specialty training. Our HMDP is comparable to the post-residency fellowship.

THC: Given that one can easily memorise anatomy and ace exams, can one pass the doors of surgery and still be a lousy surgeon technically? Or is a surgeon defined by his hands?

AR: I would say that 90% of surgery is in the capabilities of most surgical trainees. Only 10% of the procedures require extreme finesse. The development of clinical judgement, on the other hand, is much more important. This is what we should be aiming to achieve in our AST, BST and other training programmes. The importance of professionalism must not be forgotten.

I feel that technique is something that can be taught and learnt, and most people will become competent. I don't think there are many surgeons who are technically poor. The discrimination only becomes evident in the case of highly complex problems; those that require both technique and judgement. Intuition, experience and a good attitude are attributes that cannot be taught easily and take time to develop.

THC: Can you share with us who are some of the important influences in your life?

AR: I lost my father early in life, so I looked up to my mother. I come from conservative family; fortunately we were reasonably comfortable financially. My mother made us appreciate the value of education, and I am entirely grateful to her. Besides myself, I had two sisters, so as the only son in an Asian family, I understand the significance of her sacrifices to have sent me away for studies. My wife, Mary, too has been a great influence on me.

THC: Are your children doctors?

AR: We have two girls. Shakina, my older daughter, has selected obstetrics and gynaecology! She is in her second year as a trainee and has just finished her stint at KKWCH, and is back at NUH. Our other daughter, Shanaz, graduated from the University of Pennsylvania (Finance and Engineering). She is working in New York. Of course, Mary is always very busy in O & G, but we seem to have managed!

THC: What do you do to relax?

AR: I enjoy cars and driving. I don't collect cars! I belong to a small group who drive a lot. It's a varied group, we have doctors and bankers and others of different professional backgrounds. It is good fun. We drive, not race, almost every Sunday to Malaysia. Mary occasionally joins me; it's quite safe to drive up to Malaysia as we communicate constantly and go in a group.

My other interests are music and reading. I used to play the violin but regrettably I've stopped. I am a fan of modern crime fiction and history (medical and general). At present, I am reading a book called "Blood and Guts: A Short History of Medicine".

THC: Thank you for your insightful answers. SMA