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SMA NEWS

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NATIONAL MEDICAL EXCELLENCE AWARD WINNERS 2009 ISSUE (PART 1)

INTERVIEW WITH PROFESSOR NG HAN SEONG

By Dr Toh Han Chong, Editor

An inspiring mentor who has nurtured many young doctors throughout his career, Prof Ng Han Seong was conferred the National Outstanding Clinician Mentor Award on 22 July 2009. The award recognises individuals who have contributed substantially in the training of young clinicians and clinician scientists through mentorship.

Prof Ng obtained his MBBS in 1974, and subsequently completed his M.Med in 1977. In 1995, Prof Ng established the sub-specialisation of Gastroenterology, and spearheaded the Department of Gastroenterology and Hepatology. He was voted Best SGH Teacher in 1995, and appointed Chairman, Division of Medicine in 2003. He later set up the Department of Family Medicine and Continuing Care, which seeks to bring the strengths of family medicine into the hospital care environment. Prof Ng was subsequently appointed Chairman, Medical Board in 2006 and was appointed Adjunct Professor by the Duke-NUS Graduate Medical School in March 2008.

He was President of the Gastroenterological Society of Singapore and founding member of the Asia Pacific Association for the Study of Liver Diseases, as well as Director of the Bao Zhong Tang TCM Centre at SGH.

Photo credit: Singapore General Hospital

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Prof Ng Han Seong, National Outstanding Clinician Mentor Award 2009.

THC: Congratulations on being recognised with the National Outstanding Clinician Mentor Awards. Can you share with us your feelings on the conferment?

NHS: Honestly, it came as a surprise – the awards procedures were kept so quiet, I did not even know that I had been nominated. I am indeed delighted and honoured – I have been teaching, mentoring and looking after patients for more than 30 years – and this award is recognition for the hard work put in. I got the award because my students have done well; they are now heads of departments, consultants and senior consultants. I also won because I had great teachers who helped to shape my life. It was a gift from them – my dear teachers and students.

I consider myself very lucky, as I chose to work with very strict bosses – Prof R. Nambiar (Surgery, Thomson Road Hospital), Prof Rajan (Middle Road Hospital) and Prof Seah Cheng Siang (MU III, SGH) and was given the opportunity to learn and develop, as well as allowed to excel. Perhaps my undergraduate records helped!

There was an even bigger surprise for me that night, something which touched me, and will motivate me to struggle on for a few more years: After the awards ceremony, I was called to the table by Mr Liak Teng Lit and Dr Lau Hong Choon, where Prof Nambiar was seated. They told me that Prof Nambiar wanted to let me in on a secret he had kept for more than 30 years. I gladly went over, getting a bit excited, as I have gotten used to his scolding in perfect English during my houseman days! To my delight, Prof Nambiar told me, "I gave you a Grade 1 for your assessment when you were my houseman; you were the first I gave a Grade 1 to, for a stretch of 12 years. I didn't tell you and kept this a secret for more than 30 years!" When Liak quipped in to ask why, Prof Nambiar replied that it was because I could answer his questions during ward rounds, some of which even the registrar couldn't. Well, that made my day. Imagine getting a Grade 1 from Prof Nambiar!

THC: Did you always want to be a doctor?

NHS: No, my original aspiration was to be a production engineer. A product engineer does reverse engineering so as to better an object, and the process fascinated me.

In my Pre U days, we either had "engineering class" where the emphasis was on mathematics and physics, and likewise for "medicine class", botany and zoology. As I was enthusiastic about taking up engineering (I was then in "medicine class"), I studied mathematics on my own, and took biology instead of botany and zoology. Upon passing, I could take up either engineering or medicine but I realised that I could not study product engineering locally, and would have to go to the US. As funds were limited, that dream could not be fulfilled. Thus, medicine was seen as the next best choice.

Medicine did come naturally to me as I was brought up in a Chinese medicine shop; my grandfather was a practicing Traditional Chinese Medicine (TCM) physician and I helped to run the shop. On hindsight, it was almost like a clinic setting complete with patients. Although I did not manage to fulfill my dream, I think I have done well so far.

THC: Were you always a good student?

NHS: I was a consistent student throughout my schooling days; I am my own benchmark, and it would be surprising to my grandparents if I came in second. I was awarded the ASEAN Scholarship for Medicine. I graduated from the University of Singapore with Honours in Medicine in 1974 and was awarded medals for topping the class in Surgery and O&G.

THC: Who and what were your deepest influences in medical school?

NHS: Most important were my teachers. I have fond memories of the very strict (and also fierce) ones – Prof Ong Siew Chey, Prof Seah Cheng Siang, Prof Wong Hock Boon and Prof R. Nambiar. They were great teachers and role models; they set standards and professionalism, and were also the governance. They shaped us students to be responsible and accountable, and to be good doctors. These mentors took a lot of pride in their work; it is much less so today.

I was a hostelite in KE VII Hall where I stayed throughout my 5 years in medical school. It was a totally different environment from home. I almost "grew up" from the very next day I entered KE VII Hall – the songs I heard and sang, the language used, the different lifestyles, the ragging and so on. It was a totally different expectation and experience for me. I still remember the things that I did, and events that happened during my KE Hall days!

THC: How did you decide to enter the field of gastroenterology?

NHS: My first love was neurology. I was very fortunate to be taught by Professor Sir Gordon Arthur Ransome during my third year medical posting in MU I. I was the group leader, and used to carry his very heavy "bag" all over SGH with him when he went around answering consultations. I was amazed by the contents in his bag – tendon tappers of varying sizes, stethoscopes, and Cussons baby powder. He was such a fantastic diagnostician and neurologist – the flair with which he percussed the chest and abdomen, and the way he executed a tendon jerk and palpated the abdomen (after application of the baby powder).

I remembered that during one of Prof Ransome's tutorials, we marched down to Surgical B, SGH to see a post-surgical patient who became irrational and was having tremors. Prof Ransome did a brief examination, shook his head, made a turn around and we went back to his office in MU I. He told me, "Boy, there is a bottle of brandy somewhere in my small cupboard." I rummaged through the mess, and found it. We marched back to Surgical B, where he ordered me to pour about half a glass of brandy, and offered it to the patient. The ward sister and the tutorial group were shocked, but I could see the patient's facial expression of approval. He gulped down the brandy, and we all went back to MU I to continue with our tutorial. Prof Ransome later told me that the patient was suffering from alcohol withdrawal! I later went back after the tutorial, and found the patient fast asleep. I must say that medicine was practiced with much finesse in those days, even without the technology that we have today.

All these impressed me. Then came Dr Loong Si Chin and Prof Seah Cheng Siang in my final year. They too gave fantastic tutorials in Neurology.

My journey as a gastroenterologist in MU III started immediately after Dr Leong Sou Fong and Dr Ng Pock Liok left for private practice. I was a registrar then, and had to learn very quickly, especially with regards to scopes. Together with fellow registrars Drs Teh Lip Bin and Vincent Kuok, we filled the gap. That was how we started in Gastroenterology! Of course the late Prof Seah mentored us and drove us along.

My opportunity came when I met Professor Laurie Powell, a world-renowned hepatologist on haemachromatosis. He was gathering a group of hepatologists to conduct a study on chronic hepatitis, sponsored by the Wellcome Trust. The study was conducted in 4 centres – Royal Free Hospital London under Prof Sheila Sherlock, MU III SGH under Prof Seah Cheng Siang, Chiba University, Japan, under Prof Kunio Okuda and Royal Brisbane under Prof Laurie Powell. As a result of this study, I was able to spend six weeks in Brisbane and a year in the Royal Free Hospital London on paid leave. Part of the study involved reading liver histology, and I was fortunate to study under Professor Peter Scheuer of the Royal Free Hospital. I spent half a day reading liver slides, and this laid a solid foundation for me in Hepatology. From the study, we published our work on bridging necrosis in Hepatology in 1986, conducted three oral presentations at the IASL (International Association for the Study of the Liver) in 1982 and one oral presentation at AASLD (American Association for the Study of Liver Diseases) in 1985.

As a young registrar, all these became the official start of my training in Hepatology. It was great fun but hard work. At the Free, I was also involved in clinical work, mainly looking after the private patients, teaching of medical students, participating in running MRCP courses (under Dr James, Prof Sherlock's husband) and clinical research. With Andy Burroughs, we reported the biggest series of fatty liver in pregnancy in the Quarterly J. of Medicine, 1982. Upon returning to SGH in 1981, I was able to introduce what I learned to the Unit, and we started our liver histology meeting, initially with Dr Elizabeth Cheah, and subsequently, with Dr Jean Ho. This is still going on.

In 1995, the opportunity came for the Unit to break away from Internal Medicine. We became the Department of Gastroenterology, and now the Department of Gastroenterology and Hepatology.

THC: Dame Sheila Sherlock is remembered as a great hepatologist. Was her greatest forte in teaching, research or bedside clinical work?

NHS: She was the greatest, and excelled in all three. She was very strict and feared (but had a kind heart). Her clinical judgment was superb. In 1980, we did not have much technology or even molecular tests, but she was right most of the time. She was passionate about the things she did. When there was no space for research in the old Royal Free, she built

a laboratory on the roof top, and we had to climb up using a wooden ladder! It was affectionately called "The Attic". Her clinical research covered almost all topics in Hepatology. Her book on liver diseases was a classic. She was also the perfect teacher, and she was given the lousiest students to teach! She would teach them and take tutorials on all subjects, ranging from cardiology to neurology. She often told me that she did her MD on cardiac failure and liver congestion. She did all the cardiac catheterisations herself!

Like Prof Seah Cheng Siang, she was the governance as well as the quality controller. High standards of practice and patient care were expected from everyone working with her. She instilled values like discipline and perseverance in our work. Prof Sherlock was never selfish; she was willing to share her knowledge. She was generous with her feedback and criticism – feedback could be quite harsh but we could take it, whilst hard work was recognised and rewarded. I was sponsored by the Department on numerous conferences and meetings in UK and the US. She had personally asked her secretary to register me for all these meetings!

THC: You mentioned that technology takes away the edge from diagnoses, and bedside care. Do you think that this presents a threat to today's physicians?

NHS: Technology can be seen as a double-edged sword that detracts from the Art of Medicine. However, we can't practice medicine without all these advances, can we? It depends on how we weave them into clinical settings. Medicine is still a unique one-to-one clinician-patient relationship; talking and touching a patient is important, and the patient still expects to be examined and talked to. Reassurance could be just what the patient was seeking. As Chairman, Medical Board (CMB), SGH, I receive many complaints from patients who criticise their doctors for looking more at the computer screen rather than at them.

Appropriate use and knowing the limitations of technology form part of the Art of Medicine. Normal tests and scans may not reveal or solve the problems

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of our patients. On the other hand, no matter how well we percuss or palpate the abdomen, we need an ultrasound examination to pick up early liver cancer. What we need is to re-look and re-invent the way we approach clinical problems, and better use of clinical pathways.

We cannot run away from IT; access and retrieval of information is so much easier now. It can also function as a convergence point for patients and other medical information. People like myself, who are of the older generation, ought to learn and re-learn on how to use IT.

However, we should not forget or abandon the core values of doctoring. It is the duty of senior doctors to advocate and be examples to the younger doctors, and to rub off these good values.

THC: You can be considered a "production engineer" now, because you are CMB of the largest teaching hospital in Singapore encompassing complex operations and systems. What have been some of the challenging experiences so far?

NHS: Challenges are plenty. I have a tough job – administration (70%) and clinical/teaching (30%). I have given up clinical research; it is easier to look after patients. As an administrator with limited resources, I have to prioritise and ration. As a doctor, I can always give the best to my patients but as CMB, I have to deny some doctors of their requests. I have to overcome this internal personal conflict.

Retaining talent is problematic as well, and we have a reducing pool. Salary and other monetary issues have a part to play. Comparatively, the private sector pays more. We have other duties such as teaching, mentoring and conducting research, and as a result, there is always not enough to go around.

SGH is so large, and I must be familiar with almost everything that is going on in the hospital – KPIs to achieve, patient waiting time to be managed, standards to be maintained and so on. I am quite lucky as I have a great team helping me.

Expectations of patients need to be met, and satisfaction is now replaced by experience. Given our greying population, cases are more complex and hospital stays are becoming longer. We have to work hard to build up partnerships with the community and step-down care to facilitate the discharge of such patients.

Indeed, production engineering and systems engineering would come in useful here.

THC: Do you think that there should be a step-down care facility within the Outram campus?

NHS: We should, but as we are on prime land, extra space is scarce. We have to collaborate with our GPs and community hospitals to provide continuation of care for our chronic sick. If not, they will be stuck in SGH and reduce the number of acute and elective beds.

THC: The Singaporean patient mindset may be such that they may not wish to move to step-down care, due to the belief that SGH or other acute tertiary hospitals have better clinical and holistic support systems. How can we convince them to move to a step-down care facility?

NHS: SGH is not doing that well as compared to other hospitals. We do not have a community hospital in our vicinity where continuation of care can be carried out without the problem of distance. Being physically linked by a sky bridge or being across the road helps to reassure the public that specialist care is at hand, and also provide the assurance that this step-down care is part of the bigger campus.

In SGH, we have to work on being partners with the community hospitals and GPs. Our family medicine doctors

and nurses match such patients to community healthcare and GPs near their home. By being partners, for example, through providing visiting consultants and medical officers on rotation, we are also involved in patient care in the community hospitals, and thus assuring the public that we are part of the community healthcare team.

THC: Hong Kong's academic system is overall strong with reputable academic departments. Do they have a different hospital culture?

NHS: Singapore and Hong Kong's academic system evolved from the British model. In Singapore, we focused more on service and teaching in the past, and somehow neglected research. The lucrative private practice in Singapore has reduced the talent pool in the academic departments, and the disparity in income between the service and academic doctors also accounts for the lack of interest in research. Hong Kong has stuck more closely to the British model, and their specialist and academics, being paid better and having a more conducive academic environment, have generally stayed away from the private sector. They have more hospitals, beds and clinics for their patients, and although patient load is still high, they are more evenly spread out and the doctors in Hong Kong's academic departments generally see fewer patients as compared to Singapore. They have more 'protected' time to pursue research, and thus their research culture is certainly better than ours. Having a greater pool of talent always helps, as it ensures competition. Singapore is catching up fast, and there is still hope.

THC: Research plays a role in creating the reputation of an institution. How does a busy, high-performing hospital like SGH have time to do research?

NHS: SGH has a high patient load – I feel that this is a strength rather than a weakness – and it is up to the doctors to make the best use of this strength, for example, in conducting clinical trials we need numbers. We certainly need more doctors to deal with the load, thus allowing those interested to have protected time for research. Time can be created by better management of work load. However, having the passion for research is more important. Creating a career path for those interested in research is equally crucial and SingHealth and SGH have already done so. We need more mentors in SGH and a stronger research culture.

Medical Staff, MU III. 1975. I was Medical Officer, second from the right, standing. Photo credit: Chairman, Medical Board.

THC: A senior gastroenterologist in private practice once commented that he left the public healthcare sector because he had to cover subsidised care, private care, teaching, as well as conduct research. As a result, he felt that he did not fulfill himself justly in any category. What do you have to say with regards to this?

NHS: My answer to that is this doctor did not manage his time appropriately and was doing too many things. He should be what he seeks, and he must link purpose, passion and work. He is responsible for his own development and career. He needs a balance and may have to focus on solely patient care and teaching, and doing less on research, or vice versa. To cite an example, I gave up clinical research when I went into administration. As the demand for administration increased, I did less teaching. I was willing to 'give up', so as to gain on other things.

THC: How do you select and nurture talent?

NHS: Successors should not merely carry on from their predecessors; they must bring in new perspectives, work views and a new level of energy. These are important for progress. However, the overall alignment must be congruent; no one wants their successors to disassemble their work unless it was accomplished wrongly in the first place.

I often use a simple test/assignment for my doctors – formulation of the call/ward rosters and the recall of patients for our clinical examinations. These need a lot of people skills and organisational acumen, bargaining and trading. If the job is done without needing me to intervene or arbitrate, this doctor has demonstrated important basic skills in diplomacy and leadership. He/she has also been accountable as the timeline for these assignments is fixed, and can't be postponed.

Prof Seah once told me that in order to keep the service going, we must have a team consisting of a consultant, senior registrar and registrar, all prepared to move up or down. The Unit must be ready for sudden resignation, and thus a team has to be nurtured instead of an individual. Succession planning has to be carried out at all three levels.

Selection for the right people is an important task for the Unit. Like Prof Seah, I am known to be strict and meticulous. The culture for hard work is well known but I am glad to say that those who came to join me have stayed on; they have self-selected. As teacher, mentor and head, we have to walk the talk and be their role model. We must recognise and reward hard work.

THC: Can you share with us some fond memories of your illustrious career as a doctor?

NHS: When I was just back from the Royal Free Hospital London, I saw a twelve-year-old boy the very next day during ward round. He was semi-comatose and deeply jaundiced; I looked into his eyes and realised that he had Kayser Fleisher rings, and we were right, he had Wilson's disease. The patient would need a liver transplant in the present context as he was already quite far gone. We treated him with penicillinamine and gave supportive treatment. It took a long struggle before the clinical benefits appeared. He is still my patient now, happily married with three children. I also got hold of his two brothers who had a similar condition and treated the whole family. It was almost a miracle that he survived, and I find this incident very rewarding.

There was also a family of 6 – four brothers and two sisters – who were all Hepatitis B carriers. The brothers all died of liver cancer one after the other and I saw the two sisters, who were very worried that they would follow their brothers' footsteps. I reassured them that they should be alright with follow-ups. I saw them when I had just turned registrar and I am still seeing them now. Both did have liver cancer and underwent definitive resection and are well. They are both grandmothers now, and say that they no longer worry.

These patients are now great friends of mine.

THC: In Duke-NUS Graduate Medical School, one has to mould students into good doctors at the end of four years. What is your opinion on this? Is four years sufficient time to achieve this?

NHS: These students are different in their pursuit of knowledge – they are highly committed, motivated and hardworking as their syllabus is crammed into only four years. These students are also more mature, very proactive and ask different sorts of questions; I am confident that they will do well. Credit should also be given to their teachers. I must also say that SGH campus has good, committed doctors who are also good teachers. My wish is that they can dedicate more of their time to teaching rather than shuttling between schedules. This, however, has to do with reimbursement as well. Given this issue, SGH is trying to work towards a package, rather than piecemeal options. We should do our work without worrying about money to be better teachers and clinicians.

1969. 1st year Medicine, with my group mates, outside Faculty of Medicine Building (Presently the College of Medicine Building and Ministry of Health). Photo credit: Chairman, Medical Board.

THC: To you, what are the virtues of a good doctor?

NHS: Doctors must be knowledgeable to do their work properly and have professional integrity. Of course, good doctors should like people, and it is important that they be taught to communicate well. A good doctor also has compassion and is altruistic; after all, the patient-doctor relationship is a special one, otherwise it becomes too transactional. Also, a good doctor is not afraid of hard work or difficult situations like breaking bad news, and is able to share and nurture others through teaching. Most importantly, a good doctor is responsible and accountable, and unafraid to admit his or her mistakes.

THC: What do you do to relax?

NHS: Administration takes up nearly all of my time, and I am also asked to sit on various committees. Before I was too involved in all these activities, I still had some time to collect Chinese porcelain pieces from quaint shops and warehouses around Singapore. I also like to collect wooden furniture and from these I learnt many things about the history and culture of China.

I am deeply passionate about TCM, this is partially due to my grandfather. I was trained in acupuncture; but as it was in the traditional format, it is not recognised today. With these interests, we started research on East and West influences in medicine – we have received a grant for TCM herb treatment on myelodysplastic syndrome. In order to understand TCM better, I will spend half an hour every night improving my scientific mandarin. One should be open to TCM and help to seek new evidence, for example, with regards to treatment of chronic illness and cancer.

I also enjoy cooking Chinese dishes; I learnt to make Peranakan dishes through my grandmother. Since becoming an administrator, I try to keep one weekend free, solely for relaxing and maybe cooking. I will have *yum cha* with my mother and brother every Sunday morning, just to catch up.

Chess is also another of my interests, and in English College Johor Bahru, Dr Yeoh Bok Choon, who was the State Surgeon, and art teacher, Mr Lim Teck Siang, used to coach me until my Pre-U days.

In addition to all these, I used to paint as well. Unfortunately, all these activities have now been shelved. My interests are very "Chinese", although I did not attend Chinese schools. This is due to having been brought up in a TCM shop – my parents and grandparents were Chinese-educated – we speak Hakka at home.

THC: Thank you for sharing your time with us and for your insightful answers. SMA