Interview with Prof Fock Kwong Ming

Professor Fock Kwong Ming is currently a clinical professor at the Yong Loo Lin School of Medicine, National University of Singapore. He is also a senior consultant gastroenterologist at Changi General Hospital (CGH). He was Master of the Academy of Medicine, Singapore (AMS) from 2008 to 2010. In April 2011, he became an Elected Member of the Singapore Medical Council (SMC).

SMA: What was your life in medical school like, and could you share one or two of the most memorable experiences of being in medical school?

Prof Fock Kwong Ming – FKM: That was such a long time ago! There were so many incidences and experiences in all. The other day, Prof Arthur Lim asked me to go to the Medical Alumni, and there were some students there, which made us recount the good old days.

There were quite a few very significant moments in the good old days. For instance, the Medical Alumni was strong, SMA was a very strong professional body, and so was AMS. When I was in Singapore General Hospital (SGH) Medical Unit 2, Dr Charles Toh, Dr Fong Wai Poh and Dr Lee Guat Siew were there. There were all these functions at the Alumni, and to be invited by the seniors or the teachers to attend was a major treat for us. We seem to have lost that. There was a sort of peer recognition, and also apart from being in the wards and the medical faculty, you had this feeling that you belonged to the medical community where your seniors looked after you and you had something to look forward to. I don't think you have that anymore.

During the orientation, we were invited by the seniors to an initiation dinner at the Alumni. I got a skeleton at a very low price and a whole stack of notes on Biochemistry. At the dinner there were 30 or 40 tables, and there were two or three freshmen at each table and the rest were seniors. I remember one student was leashed and asked to sit under the table for the duration of at least one course of the dinner. After that he was asked to stand on a chair and announce that he was so-and-so's brother, and everyone responded, "So what?" It was a lot of fun.

SMA: Ragging?

FKM: I'd avoid the term "ragging", it was fairly harmless and nobody came to any physical harm. It was a lot high spirited fun and a social way of getting to know people.

The second experience, as an undergraduate, was attending the combined departmental medical rounds at SGH. There was a very hierarchical system which I think will not be too acceptable nowadays. The senior people sat in front and everyone else sat in the back. They tried to solve post therapeutic or diagnostic challenges. Finally, the senior clinicians would have to put down their money on what they thought the right diagnosis was and the pathologists would reveal whether it was right or wrong. That was a big challenge!

SMA: How did you make the choice to enter Gastroenterology?

FKM: It was a combination of factors – a certain amount of interest and opportunity. I had several other opportunities in Respiratory Medicine and Cardiology which I turned down. At that time I was at Toa Payoh Hospital with Dr Chua Kit Leng. I found Gastroenterology to be quite satisfying as it requires intellectual powers and manual dexterity. So that's why I chose it.

SMA: And your mentors in Gastroenterology were?

FKM: Quite a few! Dr Chua Kit Leng, Dr Ho Kok Thong, Dr Ng Pock Liok, and Dr Fung Wai Poh, who was a very interesting tutor. And of course there was Prof Seah Cheng Siang.

One pretty unusual thing was that I had the opportunity to receive training outside of Singapore – in Australia, and subsequently I spent six weeks in Europe. The Australian trip was extremely rewarding because I went at a relatively late stage in my professional career; I was a senior registrar when I left. The first thing that struck me was that what we

Prof Fock (right) and Prof Tan Kok Chai at the AMS Induction Comitia in October 2010

took very much for granted as standard practice in Singapore may not be standard practice there. You had to justify why you did a certain thing in a certain way.

Evidence-based medicine was something that came very much later. At that time I was already in AMS. Dr Ong Yong Yau, Dr Tan Ser Kiat and I went on a trip to Scotland where we met James Petrie. He was a most interesting man but unfortunately died relatively young. He was the one who helped us to understand evidence-based medicine. Then we started to write the practice guidelines. That was an eye-opener for me.

A quantum leap forward was another concept that came up – clinical pathways. All of us as doctors hate clinical pathways, and I also spoke up against them. At that time pathways were going nowhere, they were meant to shorten the average length of stay (ALOS). Much later, it dawned on me that you can merge evidence-based medicine with clinical pathways, then you have a very powerful tool! For instance, screening for colorectal or breast cancer. Is that evidence-based? If that is so, then in your pathway when you manage a chronic disease, it should be there. Another example is the usage of aspirin beta blockers in the management of patients with acute myocardial infarction.

So those are the few instances that we can see, by putting such key interventions in your pathways, it not only shortens ALOS but also improves patient outcomes.

SMA: What were some of the most memorable events of your time in AMS?

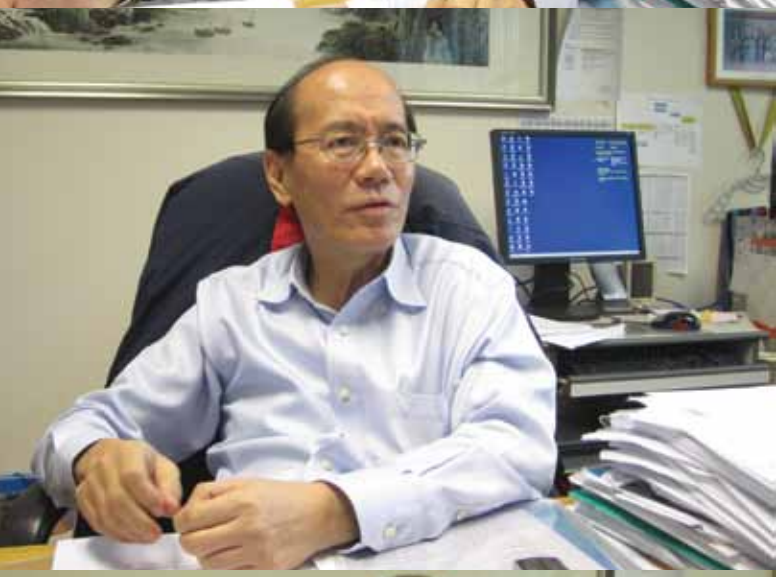
FKM: It was in 1991. When I came back from Australia in 1984 or 1985, we were invited to draft training guidelines for Gastroenterology. It took us many years to complete. It was finally accepted and launched in 1991. It was the first prototype before the term Advanced Specialty Training came along. The reason why I was asked to do that because I was in Adelaide and the head of department was retiring. He was a past President of an Australian college, so in his retirement he was asked to do training guidelines. So he would come in and run his ideas past the department. So I became very interested in that.

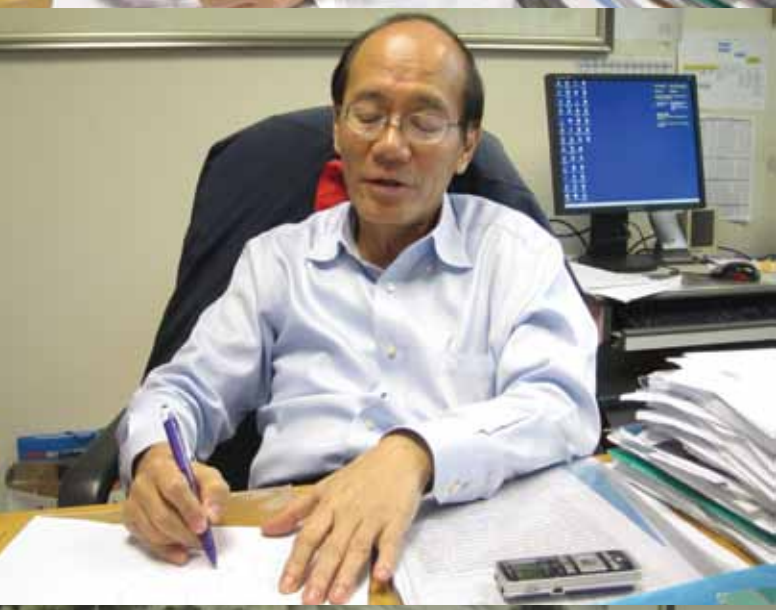
Medical education in Singapore

SMA: Over the years, have you seen many changes in medical education, both good and bad? What are your comments on these changes?

FKM: There are so many changes that one can go on for hours! But at the top of my mind is that we now spend a lot of time trying to improve the way of teaching, whether it is problem-based, tutorial groups, interactivity and so on. The latest word is experiential learning. I agree that how you are taught is important but please spare a thought for the content – that is what we should really spend time thinking through.

When we talk about content, what usually happens is, oh you're in the National Cancer Centre, tell me five conditions that the doctors should know? And you put down breast cancer and all that. Although there's nothing wrong with primary diagnoses, it is disease-specific. Core knowledge should begin with, but should not end with that. Why do I say that? Because in the world we are practising in today, patients don't





come in with one diagnosis. There's a group of conditions that we now label "comorbid", but they are just as important. For instance we see a lot of patients with many more conditions, such as cancer and chronic hepatitis. If you don't look after the chronic hepatitis, they die. Way before it was described, one of my first patients had lymphoma. He was a national serviceman with concomitant chronic hepatitis B. So I sent him to the lymphoma group. After six months on the programme, he died. When he turned jaundiced, they sent him to SGH Medical Unit 3, where they tried to salvage him, but to no avail. There were no antivirals at that time. Subsequently, after that case, I became very conscious of this. The second tier should be comorbid conditions as they can influence your interventions.

That may be sufficient up to a certain extent, but the third tier to me is to see the patient as a whole. When I say that, I mean that you have to look at him as a father and a husband. I watched this video on screening colonoscopies by an American called Douglax Rex. It not only teaches you how to do the procedure and how to prepare the patient for it, but also teaches you how to obtain informed consent. It involves telling the patient what the dangers are, like perforation and bleeding. Rex went one step further. One of the worries of a colonoscopy is missing an adenoma or a cancer. How can we explain this to the patient without putting him off? That is a major issue in the US now. But Rex did it very well. He explained to the patient that there was a risk of missing, and how he was going to minimise this risk. He was very clear in his explanation.

So this is the next level – seeing the patient as a social unit, ethics and informed consent. We don't teach things like clinical quality, timely intervention and so on, in medical school. When the students graduate from medical school, they are expected to pick this up along the way. I think the seeds for clinical quality should be planted during undergraduate days. We can amplify these aspects when they are practising, but I think it is far too late to begin when they become junior doctors. Something that we introduced in CGH but is now in the main curriculum is communication. We never went through a communication course. When I was examining for MRCP, I discovered that communication/ethics was a compulsory station. I had the experience of examining with an examiner who was very interested in communication. And when we did this station, he took the every opportunity to test communication skills. It was an eye-opener for me. He wrote a book subsequently, and we also launched a communication course here. I'm happy to see it has been incorporated in the mainstream undergraduate curriculum. This was very recent; six or seven years ago.

SMA: If you could change one thing about medical education, what would it be?

FKM: One of the things I wish for is that we should adopt a system view towards education, comprising two parts. The objective of education must be very clearly visualised and stated. I have listed the three tiers which I think are relevant. It is insufficient to train a doctor only at tier one. Such a doctor will only end up signing referral letters every morning: comorbid, not my business. We know some disciplines which do that all the time.

If he knows tiers one and two, but has not been properly taught communication, ethical considerations and all that, he might get into trouble with SMC. He might not choose the most cost effective way of managing the patient, and he has not enough insight into risk management, clinical quality and patient safety. If we can bring this concept all the way to the powers that be including the Deaneries, this could be a major change. We spend a lot of time on how to teach but not what should be taught.

The new residency programme

SMA: What do you think of the new residency programme vis-a-vis the old training system? There is a lot of anxiety over whether we can achieve the norms set out by the Accreditation Council for Graduate Medical Education (ACGME).

FKM: The ACGME residency programme has a lot of advantages, but I have some queries on their norms. As a concept – those are the details – it became very clear to me that education and training should be on one side, and accreditation and examination on the other. Otherwise, there are a lot of conflicts of interest. You have a situation where you sit and interview someone who wants to do Oncology, you take him in and he comes to your department, he works under you and you say he is a good chap. Finally you set the exam questions which are the ones you've been asking him for the last three years during his posting with you! I think it is too iffy and mashed up together, and there is no clarity of job and function. It does not mean you cannot be an examiner, organisationally you should be separate.

In the old system, we did try very hard. When your trainee comes in, you declare your conflict of interest and say you won't set the questions for the exams. Having said so, if you help to set the questions, there's still a certain degree of conflict of interest. The powerful thing about the residency programme is that it separates the training from the examinations. The training is done entirely by ACGME. Therein lies its first strength.

The second strength of residency training is a structured programme. The British got very upset with me when I said that the College of Family Physicians programme has a loose structure. Now the difficulty comes with the norms and working hours. There has been a meta-analysis, believe it or not, on the number of hours junior doctors should work and if there are effects on patient care. The answer is that getting more hours to rest does not lead to better training. ACGME is completely wrong here, the meta-analysis has proven it. We might be able to persuade ACGME to have a rethink in the light of new evidence. I read a paper of a study done, and they found that the only thing it does is give junior doctors more time to have a social life. Other papers also suggest the surgeons are less skilled if their time is too protected. By protecting the doctors' time, one of the other effects is an increasing number of handoffs. For example, you work four hours and then you have to go off. So you hand over to the next resident, who then does the same, and the number increases. ACGME stresses a lot on handoffs. A group has to sit down and look at the new evidence, not just at the local but international level.

I am in favour of a structured programme like what the ACGME is proposing. I am also in favour of separating education and training from accreditation and examination. But working hours need to be revisited. This is particularly relevant in the light of new information that is coming up in the literature.

SMA: The problem with the residency programme is that it makes you make a decision very early in your career. By your final year, you need to decide what you want to do. Do you think it is that a good thing to compel a young person at such an early age?

FKM: It's a double edged sword. For those who are very clear on what they


Giving a speech at a conference

want to do, it will allow them a more efficient route. For those who are not – speaking from my own personal experience, I did quite a few things like intensive care before settling into Gastroentrology, I would have had to make quite a few exits if I had gone into the residency programme. We have seen quite a few trainees in the traditional system where they move from one specialty to another.

SMA: Do you think the residency programme will lose the master clinicians like yourself and Prof Chee Yam Cheng, who have such a breadth of experience?

FKM: This is a very tricky subject. It is not so much the residency programme but the organisation of the departments. Look at the American system. I am familiar with Gastroenterology training in the US. The first part of any training states categorically that Gastroenterology training should be conducted in the context of a department of Internal Medicine. To do it in isolation in a Gastroenterology department, without the big umbrella of Internal Medicine, you tend to get lose sight of the forest and get caught up in the trees. Same thing for Surgery. So we need to change some of the departments to fit into that or go back to what we said about "core". So whether your training is in Oncology or Cardiology, you must have a certain amount of core Internal Medicine, General Surgery and so on.

Risk management in hospitals

SMA: You are the Chief Risk Officer at SingHealth. What does that mean?

FKM: That is a good question. We can draw three circles – quality, patient safety and risk management. They tend to overlap. I can give you an illustration and the point will become clearer. We talk about service quality in hospitals now. That is actually a measure of accessibility from the patients' viewpoint. It gives you an idea how healthcare is delivered, whether it is courteous, communication with family members and so on.

From the clinicians' viewpoint, that includes doctors, nurses and to some degree, the allied health professionals. You try to do things in a safe way that you know will promote patient safety.

With all these programmes going, you may not realise that there are unmet needs. One example is in fire safety in SGH. That is something that we don't quite think about in terms of quality. We think a little about fire safety in connection with patient safety especially when the Joint Commission International comes along. Now if you extend the thought, have you have thought of getting the fire engines into those narrow roads in SGH? All of us assume that after we evacuate, the fire engines will arrive and put out the fire, and then happily ever after. We don't realise that first, there are traffic issues like double parking, and people even park in front of fire hydrants when they're desperate enough. Fire engines are big vehicles, how easy is it to drive a fire engine into the Singapore National Eye Centre? The roads are so narrow; it would be a big challenge! And even if you can get one in, it might not be enough!

First we identify the risks, say, fire. Then we start to look at measures used to mitigate this risk and find out whether they are sufficient. Then we realise that there are some problems, so adjustments to the plan are needed. Then we go back to the quality and safety plan.

Our approach is different from traditional risk management. From our perspective as clinicians, we see fire safety as a risk. But doctors are not the best people to handle fire safety. The best people are the operations people. So we get the ops and maybe also the security people, and sit down with the fire safety brigade to work out solutions. So "enterprise" means the entire organisation, and we look at risk management from an organisational view.

It's a very big portfolio but I am not the dominant player. I have several departments of people looking into various areas. For example the persons driving the financial risk areas should be the financial people. This is the peculiarity of enterprise risk management, if you have not managed your financial risk well, you actually end up with losses. Loss can be translated immediately into loss of manpower as the Chief Financial Officer (CFO) may have to tighten the purse strings. At the clinician level, we buy fewer equipment. It may also translate into something that patients don't like, like the adjustment of fees. They're all linked.

Likewise, if we don't have good clinicians, and something happens in the hospital, patients stay away. The revenue goes down, which impacts

Prof Fock with his family

the bottom line, and the CFO tightens the purse strings, and again the cycle continues. So this is the main difference between enterprise and traditional risk management. In the latter, you just look at the clinical, financial and operations tracks separately.

That is why I think they should teach clinical quality, patient safety and risk management in medical school. We also need to teach the students how to use technology well. We have seen a lot of overuse of CT and MRI scans and so on.

Not a classical music fan

SMA: Is there something about you which is interesting but not many people know about?

FKM: Let me think. In exams and the wards, I appear very strict. Someone said my bark is worse than my bite. I don't know who the strictest is: Prof Raj Nambiar, Prof Chee Yam Cheng or me. I was Prof Nambiar's houseman. He doesn't scold but he looks at you. We mimicked him in a hospital play: "Oh dear, oh dear, how did this happen?"

Sometimes we become very strict and demanding because we think of potential harm to patients, which is what I call "NN", non-negotiable. Junior doctors should not be let off lightly, although I don't mean a Penal Code or something like that. Suffice it to say, there should be some imprints left on their memories. I remember one of my housemen, who was quite lazy and reckless. I had to chase him around. When he was in my ward he worked very hard. He told me he worked twice as hard for me as compared to other consultants that he worked for. Many years later, I met him again. He had become a successful general practitioner. We were in a group with many junior doctors. He said, "That was my boss many years ago. He tried to teach me Medicine, many parts of which I have forgotten. But the biggest thing he taught me was to stay out of the coroner's court." I thought that was a very pleasant statement.

SMA: You know you're considered one of the great feared and revered medical educators?

FKM: I don't know where you got your information from. *(laughs)* I was told by my friends that the day the young people enter medical school today, they hear of my name, for better or for worse.

SMA: What do you do for leisure?

FKM: I do play golf, and enjoy a certain amount of physical activity. Since my operation last year, I have decided to listen to my body a lot more. I go to the gym, and strictly in keeping within World Health Organization guidelines, I do at least 150 minutes of moderately intensive exercise per week.

Learning how to ski in Switzerland

I also enjoy music, pop and all that. My children will update me on what is the latest in pop. Many people on this floor are classical music fans, but not me, although I try to listen to some pieces which help me relax.

I am a foodie and connoisseur of wines. That dates from my early training in intensive care. I was sent to France. I was a registrar and stayed at the junior doctors' hostel. Every day at lunchtime we had wine, and they showed me 400 types of cheese. Nearly every day would be someone's birthday; he or she would bring a couple of bottles of wine and ask us to taste them. The French are very proud of their wines.

I also used to play badminton and squash against Prof Chee Yam Cheng, as we were in the army together.

SMA: So who used to win?

FKM: I think I can beat him, although he would contest that! *(laughs)*

SMA: If you were sent to a deserted island, what food and music would you bring?

FKM: If I were there alone, I don't think I would want soft gentle music. I want something loud like the music of the 60s. The Beatles and Rolling Stones would shake up the place! I'd bring French wine. In a place like that, you'd probably want quantity, instead of a $10,000 bottle. So mainly, thanks to my French training days, probably something from St Emilion. I'd also bring oysters and foie gras. Wine, oysters and foie gras, and the Rolling Stones. SMA