Not Just Skin Deep

By Dr Toh Han Chong, Editor and Dr Martin Chio, Editorial Board Member

Prof Roy Chan comes from a famous family of swimmers, and used to represent Singapore at many major sporting events alongside his siblings. A dermato-venerologist by training, Prof Chan is currently Director of the National Skin Centre (NSC). He also founded non-governmental organisation Action for Aids (AfA) in 1988 and is its current President.

**Going into Medicine**

**Dr Toh Han Chong – THC:** What made you decide to become a dermatologist?

**Prof Roy Chan – RC:** That’s a really good question. I was never really attracted to Dermatology as a student. However my father’s practice was Dermato-venerology to a large extent, and that was what probably first piqued my interest. As a medical officer (MO) I was posted to the now defunct Middle Road Hospital (MRH, which specialised in the treatment of skin and venereological diseases) and Prof VS Rajan was very inspiring, so my interest further developed.

**THC:** Who were the pioneers in the field of Dermato-venerology while you were an MO?

**RC:** Prof Rajan was an overwhelming figure for many of us. When I was at MRH, the other doctors were Giam Yoke Chin, T Thirumoorthy, Goh Chee Liok, Lee Chui Tho, SS Ratnam and Lim Kah Beng. Many of them are still practising, some with me in NSC, and others in private practice.

**THC:** We have seen Dermatology move significantly in two areas. There seems to be a quality of life thing with the younger people who do not want to do the heavy lifting like in Oncology. In Singapore we saw a movement towards Aesthetic Medicine. Firstly, Dermatology has become a very popular residency programme, and secondly, the issue of Aesthetic Medicine dominating the newspapers in good and not so good ways. What is your feeling about both?

**RC:** I’d be lying if I do not agree doctors aren’t drawn to Dermatology for the lower night duties and ward work. It does attract many doctors, particularly females. However, the other attraction of Dermatology is that it is an extremely broad discipline. It is often only after doctors do a posting in it, or when they attend a conference and they understand the scope of Dermato-venereology, the specialty covers a broad spectrum of internal medicine, has an increasing component of skin surgery, laser and other procedures, involves sexually transmitted infections (STIs), and public health and so on. There’s also Dermatopathology and clinical and translational research. In many parts of the world, they’ve kept Dermato-venerology, for example, in Europe, Africa and most of Asia. But in US, UK, and Australia, the Venereology part is split off from Dermatology as an independent specialty or part of Infectious Diseases. In Singapore, we’ve kept them together and are very happy to maintain this double discipline, so to speak. The breadth of Dermato-venerology allows specialists many areas they can get into.

**THC:** Yes, I think many have that impression…

**RC:** Despite the fact that it is apparently skin deep, the demand for expertise in the field is growing not from the doctors but increasingly from the public. I think it is also the duty for those of us trained in Dermatology to set standards in terms of the care of skin and not give it up to people who are not trained or are there for other reasons. The aesthetics part of Dermatology has spread beyond trained dermatologists. We cannot lay claim to being the only experts in this area, even though we are better trained than others who want to dabble in it, because we do understand the skin in its entirety than someone who just takes a course. We have no qualms about being associated with aesthetic Dermatology, it is as much a part of the specialty as is medical Dermatology and so on. In fact many aesthetic procedures were invented by fellow dermatologists and research in the area continues to be spearheaded to a large extent by dermatologists. We are very proud of this linkage and we continue to work to improve the art and the science. I think our role as dermatologists is to maintain standards and provide sound evidence-based advice to the public.
If we want specific things, I would say the significant advances are understanding the pathogenesis of common diseases like atopic eczema, psoriasis and skin cancers. Greater understanding leads to improved therapy and outcomes. Thus basic science has led to development of targeted therapies with, for example biologics. The other area would be aesthetic Dermatology, and new treatments for aging and cosmetic skin conditions using a variety of modalities like light and laser, radio frequency and so on. The other area is the global attention to skin cancer and photoaging, leading to the adoption of sun protection, not only by the fair skinned, but increasingly by darker skinned folks as well. Another is the movement away from inpatient to outpatient Dermatology. Dermatology departments all over are downsizing inpatient facilities as they are able deliver more effective care in outpatient facilities, in day care therapeutic facilities and so on. For example when I was an MO, we used to have over 30 beds, but now we have 12 beds in a population which has doubled.

We’ve seen how the Dermatology training programme used to be very Internal Medicine-based. Can you tell us about the new Dermatology training programme?

We made a decision five years ago to introduce the Dermatology seamless training programme. Dermatology is not a purely Internal Medicine specialty; a significant amount of training in surgical skills is needed, so exposure to surgery is important. In the traditional MRCP route, three years of Advanced Specialty Training (AST), people who were not very adept with their hands would be exiting and allowed to do procedures. The results were sometimes not optimal for the patients.

Training must therefore be relevant and useful. Doctors who want to do Dermatology should be put through postings that will be useful for their practice for the next 30 years or more. We needed to realign the posting requirements for our trainees. Furthermore the expansion of basic science knowledge demanded that trainees become very familiar with the new information and language. The general feeling among more senior doctors is that they don’t know much about basic science, having not had the opportunity to learn it systematically. However open any journal today and it is everywhere. What about our trainees? By and large, they too had very little exposure, and then they were thrown into situations where they were expected to know these things, pass examinations and get interested in research. Those were the two big impetuses on why we thought we should relook our programme and that’s why we have a seamless programme where people come in soon after housemanship or PGY1. Get them in young, in the two pre-AST years they will need to pass intermediate exams, and their postings will be designed for them. They don’t do all general medical postings, many of which they will never
ever use again, for example, Cardiology and Neurology. We prefer them to do relevant postings like General Medicine, Surgery or Plastics, ED, RAI, Infectious Diseases and Paediatrics. So now we have two tracks – we maintain the traditional track and we also have the seamless one, and we’ve got a 50-50 split. So it is a nice little experiment, to compare the trainees and their abilities after they exit. The first batch of seamless trainees will exit in 2013. They will emerge fully trained with their FAMS (Dermatology) but they will not have their MRCP because they will not require that.

THC: So they go through American-style exit exams?

RC: They have intermediate exams to proceed from pre-AST to AST, and these are from the Australian College of Dermatologists. Subsequently each year they do the American Academy of Dermatology In-Training Examination (AAD ITE), and finally they have a locally administered exit exam at the end of the three-year AST. We administer these AAD ITE web-based exams in real time with the American counterparts. It’s one way of benchmarking. However it is not meant for US board accreditation.

THC: Maybe one last question on Dermatology. Who are the big influences in your career in Dermatology?

RC: Doctors who were senior to me in MRH influenced me a great deal, like those I mentioned earlier. When I was at St John’s Institute of Dermatology in London for a year, there were several people who were very inspiring, like Prof Malcolm Greaves and Prof E Wilson-Jones. For my interests in sexual health, STIs/HIV/AIDS, public health, policy and advocacy, there are far too many to mention.

Making waves

THC: Let’s move on to the sporting side of…

RC: My past? (laughs)

THC: There’s this whole urban legend of how your dad threw you and your siblings into the pool and you started swimming at a young age. How did it all begin?

RC: You know it was so long ago that I can’t really remember. (laughs) I started representing Singapore in Primary 6 or something like that, and started winning medals at international level soon after that. I spent most of my schooling life as a swimmer – I swam for Singapore from Secondary 1 to the third year of medical school. Even in the army I was swimming competitively.

It was pretty strenuous. We – my family and our team – were the first people to start training twice a day. Before that swimmers used to train only once a day. We swam in the mornings before school. We’d be up by 5 am, get to the pool by 5.30 am, leave before 7 am and reach school for flag-raising by 7.30 am. After school, we’d go home and do our work, and go back to the pool at 5.30 pm. Saturdays were off days but we’d be back at the pool on Sunday morning. This was our programme five or six days a week, we reeked of chlorine most of the time. My dad, Dr Chan Ah Kow, was the national coach for a very long time.

THC: What were your specialties?

RC: I swam freestyle, backstroke and butterfly. But I wasn’t very good at breaststroke – didn’t have the legs for it! (laughs)

THC: In the history of local Medicine, there have only been three Olympians: M Jegadason, Ben Tan, and yourself. Tell us about the 1972 Olympics in Munich.

RC: Actually before Munich, there were the 1968 Olympics in Mexico City. I went as a spectator and didn’t swim then, being a little too junior. The Olympics are enormously grand now, but even in those days they were still quite big scale events.

As for Munich, it was a fantastic experience! I think I swam in five events, but didn’t get as far as we had hoped to. (laughs) It was an unforgettable experience as I swam with the best, like Mark Spitz (American swimmer who won seven gold medals at the Munich Olympics).

THC: What made Mark Spitz such a great swimmer? He isn’t exactly six feet tall…

RC: He’s not; he wasn’t that much taller than me. If you look at the current batch of swimmers, they’re all giants, like Phelps, and even the new crop of Chinese swimmers.
I think in order to swim well, you need to also be able to float very easily to cut down your resistance. I guess he was one of those people who had that natural ability. His technique was very economical. So it's all a matter of cutting resistance and propelling yourself across the water.

THC: How was Olympic village life?

RC: It was intense. What struck me was that the athletes got the opportunities to mingle, meet people and learn about their ways of life. There were theatres and movie houses as we needed to relax. You couldn’t sit in your rooms the whole day waiting for the upcoming events. There was a lot of socialising. Every team was different. In those days teams from communist states, like East Germany’s, were much more reclusive. They were very disciplined lot, compared to those from Western countries who were generally much more relaxed and boisterous.

The big thing then and now is exchanging badges with the athletes from other countries. I used to collect swimming trunks. Not before the events but after! (laughs) I do have a few gold medallists’ but not Mark Spitz’s. But they’re all old and thrown away by now. It’s one of those things that you do when you’re young.

THC: It’s like the football guys exchanging jerseys. Did you have a strict diet?

RC: Not really, we just took some supplements. I don’t think I ever took anabolic steroids! (laughs)

THC: Why can’t Singapore produce more Olympians? Are we getting there? Why is it that New Zealand, which has a smaller population than us, can produce great Olympians like their rugby team? Why can’t we do it?

RC: I think you’ve got to pick a few sports and focus on them. We already have a table tennis tradition, we need to stay the course. Of course there’s the matter of getting the right environment (training, support structures, and the like) and genetics. Stay out of the obviously difficult sports like long distance running, as we don’t have people who have to run six miles to school like some of the best Africans. The Singapore National Olympic Council and Singapore Sports Council need to concentrate on what they think we can do best. I think we should stop pinning our hopes on soccer, for example. (laughs)

THC: Do you have a particularly memorable win?

RC: I think winning in front of a home audience is probably the most rewarding. In the 1973 Southeast Asian Peninsular Games (the forerunner of the Southeast Asian [SEA] Games) held in Singapore, I think I won six gold medals. I could have won ten medals had I entered in ten events as I was at my peak then, but I thought I should give others some chances. (laughs)

When I was swimming competitively, my proudest moments were standing up on the podium with Majulah Singapore in the background. When you’re a teenager, that’s really a great accomplishment. You feel really really proud, not for yourself but because you did it for your country. And everyone is watching. That was what made the training worthwhile. A win. More young people should try to get there.

THC: Can we talk about the massacre of Israeli hostages by Palestinian group Black September at the Munich Olympics? Did the Olympians understand what was going on? What did you feel?

RC: I didn’t really understand what was going on. The action was a few blocks away from the Singapore contingent’s quarters and you could hear the gunfire. I crawled up to the roof of my block and was chased back to my room.

You know, the Singapore team was multiracial. There was a Malay boxer, Syed Kadir, and his coach called Ken Meyer, a jovial Jewish guy, who used to coach swimming before becoming a boxing coach. And it was really funny because this was a complete contrast to the situation we were going through. But you know the games are never apolitical. They have been used for all sorts of political reasons, but the Black September incident was probably the nadir.

Anyway, the Munich Olympics were my last Olympics, and I’ve never been to any since. I still watch the Olympics.
on TV but there’s nothing like competing in them and I feel very lucky to have been given the opportunity to be in Munich. The only thing that has never changed is the Singapore team uniform, though! (laughs)

**Taking action**

**THC:** As a medical professional working in civil society, what are your feelings about how the evolution of how AIDS is perceived in Singapore?

**RC:** I’ve been at AfA from day one as you probably know. AIDS is now a disease which is not necessarily fatal anymore. The treatment has advanced so far that people should be able to live normal lifetimes, though not necessarily always in the best of health. But stigma is still rife. If we say who’s to blame, although I hate to play the blame game, I think many groups have to change. We are now seeing a resurgence of AIDS in certain communities, particularly men who have sex with men (MSM). Our figures are actually quite low compared with global figures. For an equivalent-sized metropolis in the developed world, our infection rate in the adult population is less than 0.2%.

We’ve been able to keep our figures low due to the hard work of a few groups of people, but this cannot continue. We need to review the programme, seriously address stigma and things that stand in the way of better results. My view is that most people know how HIV is transmitted. However many don’t believe they are at risk, because it’s an invisible disease. Among other things, we need to update our approach to sexuality education, change the ancient law that criminalises MSM and which restricts access to education. This is the 21st century. If we are unable to modernise, we will not succeed. Another example is condom advertisements. Why can’t we talk about condoms in a clinical way – use condoms to stop AIDS? For some reason, it’s not allowed in the mass media!

**Last words**

**THC:** Do you have any hobbies?

**RC:** Hobbies? I have very little free time! But one thing left from my swimming training days is that I find the time to go to the gym for half an hour every day, many days a week. What else do I do? I do what many other urbanites do – check out new restaurants. My idea of relaxation is lying in bed on weekends at the end of a sleep-deprived week.

**THC:** What is one thing people don’t know about Roy Chan?

**RC:** The reason why I’m doing the AIDS thing is because if I see something wrong, I want to set it right. I don’t like injustice, bigotry and intolerance. That keeps me going. SMA