What is Expected of MEDICAL STUDENTS TODAY?

Text by Dr Lee Yik Voon

Getting enrolled into a local medical school continues to be extremely competitive and popular. It is not surprising that private entities are now offering courses to help students with handling medical school interviews. It is therefore important that our selection criteria must be robust to avoid gaming of the system and we need to focus on selecting those with the heart to do medicine.

I was given the understanding that our undergraduate course lacks the focus on patients. As medical students, we used to do the primary sciences and try to integrate these in the third to final years. Our medical schools no longer practise this and the current syllabus has been revised to integrate the primary sciences and clinical aspects by organ systems. This gives more clinical relevance to the teaching curriculum, but one must not forget that it is not just about the heart, bones or autonomic nervous system. The medical student needs to appreciate that beneath all these is a living soul.

Teaching today is highly intensive in terms of supervision and monitoring of progress. Each and every student is guided and trained individually to do proper clerking of history and physical examination. Students' performance and progress is monitored closely with the aid of information technology. But how do we improve their communication skills and holistic thinking? When medical students clerk a patient, they need to take into account that they are talking to a person and not just a case. They must understand and appreciate that the patient's social circumstances and/or family members can influence and have an impact on the management plan. Hence, our focus should be holistic.

Primary care vs specialist treatment

The undergraduate curriculum seems to lack a focus on primary care. The training

Photo: SMA Charity Fund

programme caters for producing hospitalists (hospital doctors) who are equipped with basic skills for looking after hospitalised patients. Medical students who decide to be primary care physicians have to take up family medicine as their specialty. However, the prevailing thinking is that any Singapore Medical Council (SMC) registered doctor will be able to practise as a GP. What is often not appreciated is that, in today's context, GPs need to be equipped with more skillsets to manage their role and that also includes the issue of litigation.

There seems to be a lack of assimilation between primary care and inpatient or outpatient specialist treatment. This happens when medical students are trained to operate independently and not in a team-based care integrated healthcare setup. This may result in managing beyond their expertise which does not benefit their patients. Under the current SMC Ethical Code and Ethical Guidelines, we need to practise according to our skillsets and capability, and acknowledge when we should refer a case to relevant specialists. Hence, it is imperative that we know who we should refer to and when we should do so.

Another subject that is missing in the curriculum is the knowledge of the various components of our healthcare system. One would erroneously assume that when one is in the system, one would know what it is all about. This is indeed untrue as specialists may not have a clear idea of primary care initiatives. As a result, when specialists need to right site their patients, the only option may seem to be to refer these cases to the polyclinics, by default. This further overloads our crowded polyclinics. I have been told that this has since improved and that hospital specialists currently ask their patients about their family doctor and attempt to refer them back to their family doctor upon discharge.

Healthcare financing and medical ethics

The lack of knowledge of healthcare financing and how the private sector works is very palpable. When will we be motivated to learn? Only when one wants to leave for private practice will one attempt to comprehend the situation in the private sector. I believe that such training during the residency period will provide good grounding for all doctors. We need to understand that healthcare costs are not independent of patients' need and concerns.

We have undergraduate and postgraduate teachings in medical ethics. However, we are not certain of the effectiveness of such teachings as evidence in the interactions we have with younger doctors. It may be present in the silent majority but we are discouraged when we read in the media of doctors who get themselves into trouble. We need to include in our teachings the SMC disciplinary process so as to improve buy-in from our younger doctors. We should set the ethical boundaries for our fraternity while allowing them to push the envelope in their clinical thinking.

For our doctors, there is no escaping the need to be familiar with medical law that is related to our medical practice. When it comes down to how we practise, there are plenty of guidelines and the reasons behind these that we need to understand. Hence, there is a need to participate in events that facilitate continuing medical education, to reinforce our commitment to medical ethics and encourage us to adopt best practices.

Sharing of best practices

Two recent examples would be the enhanced Screen for Life (SFL) programme and the Healthcare Services Act's compulsory contribution to the National Electronic Health Record. In the enhanced SFL programme, the protocol guidelines state that patients are to collect the Faecal Immunochemical Test (FIT) kits from clinics and mail it out after completion of the collection of stool samples. We anticipated a poor take-up rate. Hence, to close the loop, several members of our GP chat group decided to get their patients to return the completed FIT kits to their clinics instead.

It is unfortunate that some doctors, who heard about the compulsory contribution of their clinic data to NEHR, have fallen victim to vendors who pressured them to sign up for their clinic management software. The bill has yet to be read in the parliament and the Ministry of Health is still talking to stakeholders. By keeping in touch and talking to other doctors in their private network, be it classmates, colleagues or friends, all these could have been avoided.

In summary, some of my senior GP colleagues are telling me that we should look at "heartware" and not software or hardware. We need to focus on lifelong learning, humility and empathy. It may be too late to screen students at medical school interviews; but maybe we should be instilling such values at a much younger age. Can we achieve such a goal in this current climate? ◆

Dr Lee is a GP practising in Macpherson. He is also a member of the current National General Practitioner Advisory Panel. He is a pet lover at heart who is the proud owner of a dog, and regularly feeds neighbourhood community cats. He also enjoys playing online war games and thinks that playing Pokemon Go is a good form of exercise.