INSIGHTS INTO SINGAPORE'S HEALTHCARE LANDSCAPE

INTERVIEW WITH **A/PROF BENJAMIN ONG**

A/Prof Benjamin Ong graduated from the National University of Singapore (NUS) in 1981, before going overseas to further his specialisation in neurology. Since his return to Singapore in 1990, A/Prof Ong has served in several appointments including being the head of the Division of Neurology, National University Hospital (NUH), Head of Medicine, NUS, and Chairman Medical Board, NUH. He was also the chief executive of the National University Health System (NUHS). In 2009, A/Prof Ong received the National Day Public Administration Medal (Silver) for his leadership contributions and in 2013, he received the Long Service Medal by the President of the Republic of Singapore in recognition of his dedicated service. He also received the Public Administration Medal (Gold) for outstanding efficiency, competence and industry in 2015. A/Prof Ong is currently a senior consultant with the Division of Neurology, NUH and has been the Director of Medical Services (DMS) with the Ministry of Health (MOH) since 2014.

INTERVIEW BY **DR TOH HAN CHONG, EDITORIAL ADVISOR**

The path of medicine

Dr Toh Han Chong (THC): DMS, Thank you so much for agreeing to this interview. Let's start with the simple stuff!

DMS A/Prof Benjamin Ong (DMS): *[laughs]* Are there any simple stuff?

THC: Here is a start. Was medicine always your first choice when you were a young student in junior college (JC)?

DMS: During my time, the only JC was the National Junior College. I stayed back in the Anglo-Chinese School instead. I think I considered between engineering and medicine; partially because I've always been strong in the sciences and I enjoyed interacting with and helping people. By the time I was in Secondary 4, I was a lot keener on doing medicine and by pre-university 1, it was evident that medicine was my first choice.

THC: Do you think that your experience and training as a neurologist contributes to your role as DMS?

DMS: I would say yes for a number of reasons. It's a specialty where you need plenty of solutions. The fact that a lot of the neurological conditions are disabling meant that you had to understand the social fabric of the patients and the wider community. Placement for patients was something you had to explore as a neurologist. If you did not learn to interact with nurses, therapists and social workers, the patients would not go home. So you had to learn to manage all aspects of care from the very beginning.

Another factor has to do with the fact that many neurological conditions did not have solutions in terms of treatments that worked. So it lent itself a lot more to one being more directly involved in the whole phase of discovery or being involved in working out diagnostic algorithms, which then became part of the mainstream clinical pathways. Much of neurology is still not clear, and the field of dementia is one example.

Healthcare challenges

THC: With Singapore's outstanding healthcare system and reputation, what are some of the big challenges moving forward? Last year, the War on Diabetes was highlighted, and so was the silver tsunami and rising healthcare costs. Are these the big button questions?

Photo: A/Prof Benjamin Ong

DMS: I would say yes. We are successful because our life expectancy is now longer. For women, it's getting close to 85 and for men it's just over 80 now. However, it's not just how long you live, but also your health adjusted life expectancy that matters. For women, it's near the age of 75, for men, it's just gone over 70. Measure that against your life expectancy, and you will be looking at the number of years of disability that you will experience at that particular phase of life. With the ageing population and the shrinking birth rate that we have, the reduced number of potential workers in the country forms a challenge.

We are demographically leaning more towards patients who have chronic debilitating conditions. The War on Diabetes singles out one of the three major chronic conditions, known as the "DHL": Diabetes, Hypertension and Lipids. We want the population to be healthy for as long as possible, so the plan is to prevent or to delay complications. Improving treatment is downstream while improving health is upstream. That aspect of it is always a partnership between us and the patients.

Then there is the issue of rising healthcare costs. If your focus is on nothing but rescue treatment, which is what most acute care is about, you're increasingly shifting your rescue treatment to individuals who are further along the course of disease, and your returns diminish compared to when we go upstream to help individuals stay healthy for longer.

Medical training

THC: Now, on to training and residency! Structured teaching, good teacher-to-student ratio, and more supervision, oversight and feedback are the various strengths of the US-styled residency. Yet, along the way, even local healthcare leaders have said that the implementation has been less than ideal, and that we need to tweak the process and maybe even abandon it. Some also questioned the switch to a system that is harder to transplant and implement into a busy local culture, and not recognised by the American residency board when we had a world-class British medical training system before. What are your thoughts on this?

DMS: The residency system was put in place in 2010 so it has been about eight years now. As you rightly pointed out, the residency system aimed to do a few key things. Number one was to put structure to the curriculum and number two was to make teaching, and the supervision of teaching, more transparent and accountable. At that time, the Ministry looked into a number of potential jurisdictions, including the UK's, to see whether there was a way in which we could modernise and improve the training of doctors.

When they looked at the various internationally reputable systems, the one with the best structure to adapt then was the American system. In fact, our

British colleagues were also looking into revamping their own medical training system due to the issues with their existing system. They only came up with the new system with the revision of the Certificate of Completion of Specialist Training system recently, just before I came into the MOH.

When I came on board, we did the first review of our residency programme. The review committee then felt that it was too early for us to make a lot of changes, though they did make some important recommendations that we have already put in place.

Firstly, they agreed that medical students should not go directly into a specialty straight away. There were a number of reasons behind this decision. The students might not be ready to make a choice – there was no work-based evaluation of their capabilities or how they dealt with patients. More importantly, it was a statutory requirement, under our Medical Registration Act, that one underwent the postgraduate year one (PGY1). In view of that, the training of doctors now cannot start until after PGY1. However, you cannot implement that straight away because you have people in flight; so it will kick in in totality by next year. So, by and large, it means that we will have at least a year and two workplace-based assessments, instead of assessing potential residents purely by their examination results.

Secondly, they recommended that we better contextualise the training. We have been working together with the Residency Advisory Committees, Joint Committees on Specialist Training (JCSTs) and the Americans to do this going forward. The idea of this system being one where the Americans are charged with certifying our doctors and specialists is actually a misconception.

THC: Oh, really?

DMS: We are the ones who certify. What they accredit is the programme. The system of certification and the determination of whether a person is a specialist are still done by the Specialist Accreditation Board (SAB), Singapore. We are accountable for that but the SAB looks to the JCST to confirm that the curriculum content, examinations and evaluations indicate that the candidate is ready before the SAB considers certification.

DMS: Another point I would add is the issue of training throughput. The residency system does mean that training throughput can be more closely managed, but it also has to respond to the needs of the hospitals and our Singapore populace. Many of our young medical students and doctors have aspirations to be medical oncologists, surgeons or some other specific specialty, but in essence, we must always look at what the country needs. Thus, we should encourage young doctors and medical students to think about how they can address those needs. If you start out life saying that you want to be a doctor, you start out expressing the fact that you want to help. You shouldn't be going into it just for your own needs.

THC: On the ground, some doctors are griping about how policymakers said, a few years ago, that "we do not have enough specialists", yet now they say "we have too many specialists; we encourage you to become a generalist". Did they get the mathematics wrong initially?

DMS: The incubation period for a doctor is long, and I think it's important for us to bear in mind that when we talk about specialty and specialist, we do still need specialists. What is changing is the kind of specialists we need. It is important to bear that in mind. While I do not think that we have over provided yet, we may face a situation where we have relative excess in certain areas versus others, if we do not make some adjustments to the choices people make now. But in some areas of training, we have always been relatively short. And those areas are the ones where we have the greatest needs. So we should look into those more seriously and hope that more people will be interested in areas where we have needs – specifically geriatrics, internal medicine and palliative care. Will we still need a person who is extremely talented in a medical or surgical procedure? Yes, we do.

THC: I guess it means fewer opportunities for those interested in the more popular specialties.

DMS: It will be more competitive.

The healthcare landscape

THC: The Health Manpower Development Plan (HMDP) is another elephant in the room for our doctors-in-training. The general feeling is that it is harder to get an overseas HMDP fellowship today. One rationale heard is that since Singapore is already so strong in many areas of medicine, there is no need to send doctors overseas for subspecialty training. Another factor is that a trainee might get headhunted with attractive offers by the private sector after completing a HMDP fellowship, thus resulting in a loss to the public health service.

DMS: For HMDP, the aims have not changed, but a doctor's perspective

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towards it may have. The HMDP is a fund set aside by the Ministry to develop doctors in specific areas of national need. It is not for doctors to use for personal development alone but to serve a need of the wider healthcare system. It was designed essentially for people who have not only completed their training but have gained enough post-training experience on the ground to at least understand the broad needs of their specialties. That way, when they go overseas, the context of practice is a bit easier for them to apply. Otherwise, they may pick up a model of care that is not easy to translate locally.

On a personal level

THC: Thank you for your insights into so many important areas. Moving on from medicine and work, what are some fond memories of your own medical student life?

DMS: I stayed on this campus, in the Sepoy Lines King Edward VII hostel, throughout my five years of medical studies. This campus was, in a sense, my medical school home. What was fun about it was that when you're part of a community on campus all the time, you get to know your colleagues very well. Medical school classes were smaller then, so you knew people five years your senior, as well as five years your junior.

What I think was quite meaningful from my standpoint was the fact that once you got into the clinics as a clinical student, you were treated almost like a member of staff. Partially because there were so few of us; with very few seniors, registrars and medical officers, you became useful very quickly.

THC: Sounds like a battlefield promotion.

DMS: And you got to do a lot more things. They supervised you, they kept an eye on you, but they entrusted you with a lot more.

THC: Who are the mentors and role models who have inspired you?

DMS: Of course Prof Seah Cheng Siang was one of them. He was an extremely astute physician and a very good diagnostician. In some ways, my interest in the analytical capability came from watching him as the master-clinician. He took an interest in me for some reason, but he was strict. Another thing I learnt was how much he loved learning and how much he enjoyed teaching.

Then there was Prof Chan Heng Leong, who was then the NUH/NUS department head. Prof Chan probably helped me the most in my career development. He taught me many things about clinical teaching and how to run examinations. My first clinical teacher was actually Prof Lim Pin. However, I didn't see him much again until much later, when he came back to NUHS as a senior physician. At that time, I had just become a department head so I used to discuss certain difficult issues with him. Thus, in terms of guidance in leadership, he too, played a part in my professional life.

THC: What do you do to relax and what are your pastimes?

DMS: When you get busy, you are not necessarily always productive – that's the important thing to bear in mind. You have to schedule in time to do the things that are important. This is why I will always make time to spend with my wife.

THC: That's sweet. Hopefully she reads the interview. *[laughs]*

DMS: It is not easy, because she has a busy schedule too.

THC: Is she also a doctor?

DMS: No, she's a retired lawyer. We try to have dinner together and talk so that I wouldn't look at my work. If my grown-up children are around, that's wonderful! We try to have useful discussions with them. I enjoy sports, so I still get out and I'll go to the gym or go on walks. Occasionally, I'd play squash. I think my golfing skill is rapidly disappearing. Of course, I have an interest in music, so I still listen to music.

THC: That's wonderful. Thank you so much once again for spending this time with us for *SMA News* sharing your insights and wisdom.

For the full transcript of this interview with DMS A/Prof Ong, please visit http://bit.ly/2HsZxSb. ◆

Photo: A/Prof Benjamin Ong

Legend

1. A/Prof Benjamin Ong (third from left) when he was a clinical tutor to medical students (picture taken circa 1992)

2. Dr Toh Han Chong and A/Prof Ong pose for a photo after the interview

3. A/Prof Ong and his wife, Mrs Ong Cheow Lan Cindy, while on a trip to Yakushima, Japan in 2017

Dr Toh is a senior consultant, clinician-scientist and deputy director of the National Cancer Centre Singapore. He was the former Editor of *SMA News*. In his free time, Dr Toh enjoys eating durians and ice cream, reading, writing, rowing and watching films. Thankfully, the latter four are not fattening.