3 A/Prof Yeoh Khay Guan
– Dean of NUS School of Medicine

By Dr Jeremy Lim, Editorial Board Member

Building upon a century's legacy

Dr Jeremy Lim – JL: Looking back on your own days as a student and comparing them to the students' experiences today, what do you think has changed, for good or bad?

A/Prof Yeoh Khay Guan – YKG: The identity and traditions of Yong Loo Lin School of Medicine (YLLSoM) are still the same, but a lot of things have changed since the time we recall ourselves as students, and most are positive ones.

The curriculum pedagogy has evolved. Now, we do interprofessional team training, as we now have nursing degree students alongside medical students. The rationale is that by training together as a team, in future, they will work better in a hospital environment as a team. We have a lot of simulation training too, like a new two-storey simulated hospital and simulated patients (actors) who can give the students feedback. There are a lot of pedagogies and technologies now that we didn't have in our time.

The class is also humongous now. This year's class is 300, and that is the biggest it will get because we cannot take anymore.

JL: My year was about 127; we were the smallest cohort.

YKG: One thing I feel that we've lost is the feeling of familiarity or cosiness. If your class was a class of 127, you know almost everyone. In a class of 300, it's tougher. Even with my class of 200 back then, we probably only knew half of the class well so there's a lesser degree of familiarity with your cohort and seniors.

JL: You have got 100 years' worth of alumni, and given that some of the challenges are with school bonding, how then do you see the alumni being a valuable resource that the school can draw upon and engage?

YKG: Many of them are interested to know what has changed in the curriculum, from the perspective of parents, partly because some of their kids are coming in. But I think many of them want to know as alumni. We've been sending them electronic newsletters. What we need to do is to recapture some of the databases after so many years because some people change their emails. Slowly, we are populating the databases and sending out more information. We're also beefing up our website so people can log on to see what's happening in the school.

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We're involving the alumni in three ways. Firstly, we're inviting them to come back and help with the student selection process. Those who are interested will need to go for a bit of training. Secondly, some help in the admissions process, as mentors to students, and with a bit of career guidance. Thirdly, they serve as teachers in some types of tutorials, like bedside tutorials.

JL: There has been this accusation that today's doctors are technically superior but morally inferior. Given that they spend five formative years in medical school, what is the school's role in all of these?

YKG: Today's doctors have much more technological capabilities to help their patients. Moral atrophy is a general phenomenon in society that is not unique to Medicine. Maybe it is particularly pertinent for us because we want doctors to be moral, altruistic, and compassionate. The medical school doesn't and can't exist independent of society. We started a Centre for Biomedical Ethics, and an ethics and professionalism track to emphasise the importance of professional and ethical values to students.

JL: As you said, compassion is an important characteristic of the medical student and doctor. As the Dean, how then do you use these five years to maximise the opportunities to inculcate these intrinsic values in students?

YKG: Our take on that is that values have to be both caught and taught. It has also got to be internalised and lived out. Even if you teach the theory of compassion, unless the person is compassionate in his actions or behaviours, I think you have lost it.

We try to do all three, basically. We give them the taught part. There is a five-year track in Health Ethics, Law and Professionalism right from the first year, which tells them about expectations, professionalism, and so on. In the clinician years, it's interlaced with the clinical subject matter so that they can understand the context – what are the ethics of treating a patient in the clinic, what are ethics around prescriptions, the issues around organ transplant, etc.

The caught part has to be from their observations of what is going on in the clinics and hospitals, role modelling and so on. If they don't observe that, it will just be theoretical. They must see that there are values in action, and that can only be done by seeing it in clinical care and real life settings.

JL: Many medical schools have started to explore teaching leadership and management skills. What are your thoughts on this and what is YLLSoM intending to do in this area?

YKG: We have been looking at that for some time. There are four broad areas. To be a leader or manager, there is the communication part, the team aspect – how do you interact with the team, there is the management aspect – rationalising resources, and then there is the leadership aspect.

We have been introducing some of them into our curriculum, but at different stages because a student doesn't have to deal with management of resources for a long time, not until they are consultants. We are trying to create this track and deliver some in undergraduate education, some in postgraduate residency and some when they are going to become specialists.

JL: You said previously that YLLSoM is a proudly Singaporean school with a global outlook. How would this resonate with the 18-year-old who is deciding between YLLSoM, Lee Kong Chian School of Medicine (LKCMedicine) and overseas medical schools?

YKG: I've been pleasantly surprised because I think the students are proud to be Singaporeans. It is part of this idealism that is present in their age group, which I hope they would retain. We often highlight that the school was started by a public donation effort in 1905, so we have a duty and responsibility to the community. We strengthen the community service spirit by the community volunteer work that we do too, like neighbourhood and public health screenings. Those are opportunities to use the skills they've learnt to serve and help people. We try to inculcate the spirit of giving back to the community and the public.

For the global outlook part, a lot of the curriculum is delivered in Singapore but there is this period in year four, where they have four months to go overseas to do an elective. Some choose a traditional campus in the UK, US or Australia. By far, the most popular choice is Vellore, India, at the Christian Medical College because I think they see a different type of Medicine practised there and that gives them a broader outlook.

The second issue is competition. Is the competition within Singapore or is it external to Singapore? We're so small in Singapore that it's silly to think that three schools are competing with each other. With Duke-NUS, I think there's no competition because they're postgraduate so they take a different sort of students. With LKCMedicine, they take in similar types of applicants but we have 2,000 applicants and we can only take 300. There're plenty of students and they're all very high quality, they've got good results and so on. I don't think we're competing in Singapore. The challenge, to us, is what type of education are you giving in Singapore and how it stacks up against training you get in the rest of the world.

JL: Do you see competition for other scarce resources, such as faculty, patients, etc? Traditionally, medical schools, to a large extent, are about apprenticeship. You need mentors and a lot of clinical material, and these are scarce resources. How do you see these playing out?

YKG: As the medical enrolment is expanded, it definitely will have an impact on the clinical training spaces in hospitals, wards and so on. In some postings, it is distinctively crowded. I think we can cope with that in four ways.

Firstly we need coordination at the national level. We don't need three different groups trying to get into the same ward at the same time. The way to do that is to imagine a grid, where the timings of the postings can be spaced out so that, for example, not everyone will be there at 4 pm on a Monday afternoon.

The second thing is by expanding capacity. By the time the LKCMedicine students reach clinical years, it'll be 2016. There are two or three new hospitals coming up, in Jurong and Sengkang, so hospital capacity will also expand.

The third approach is using untapped capacities, even now. We don't use the community hospitals and ambulatory spaces much, partly because the main group of teachers are in hospitals. As we appoint more clinical faculty, we could move some student groups to do their clinical attachments in community hospitals or hospices, and send the teachers to be with them during the tutorial.

The fourth approach will be giving some types of instructions to the students in the simulation hospital, before they enter the main hospital. Some could be substituted by a well-designed simulation programme. Training in communications and history-taking could be carried out with a simulated patient first.

The residency system

JL: Do you find it difficult to persuade students in YLLSoM that it's okay to just do a transitional year or take some time to figure out what they really want to do before applying for residency in their final year?

YKG: No, I tell them my philosophy that since you are ultimately choosing your specialty for the rest of your life, you should take your time and be clear why you want to do it, like what you're good at or what you like to do. There's no rush. Doing the transitional year, and taking your time, gives you a bit more clinical experience and exposure – it is a good thing. And one year over a lifetime is nothing to worry about.

JL: You have been running the residency programme for almost three years now, have there been residents who come back and say, "I think I chose the wrong residency."?

YKG: Not many that I'm aware about. I

don't think we've systematically polled everyone and asked them, "Do you feel you are comfortable making the choice that you did?" To me, that's the important question. We haven't done a general survey, but after three years, I think we should.

The residency system brings advantages such as dedicated funding for postgraduate training and a more structured training, but the implementation was rushed and stressful on the ground. A lot of the implementation had a timeline, so the whole thing was a big rush.

Concluding thoughts

JL: What do the medical heroes of today look like?

YKG: Our challenges today are distinctly different; maybe life, and what doctors are asked to do now, has gotten more complex. There is a lot of multitasking that I'm not certain existed 50 years ago. I'm just wondering, at that time, you could concentrate on being a doctor and spend your time doing clinical work but now, you've got six different things to do, which has maybe shrunk our roles as doctors.

JL: What is your personal philosophy in life?

YKG: I guess it's hard to answer that without sitting down in an armchair and thinking about it. I try to approach life balancing two things. A good approach to life would be being aspirational and positive, and on the other hand, it is important to have a measure of equanimity and balance.

Those are my two personal philosophies. We try to do what we can to improve things. We should live our lives doing what we think is important and try to make a change so that we leave the house better than when we entered it.

Theodore Roosevelt said, "Do what you can, with what you have, where you are." That sums it up nicely. You know you're in that role and you do what you can in that role. SMA

Photo: Yong Loo Lin School of Medicine