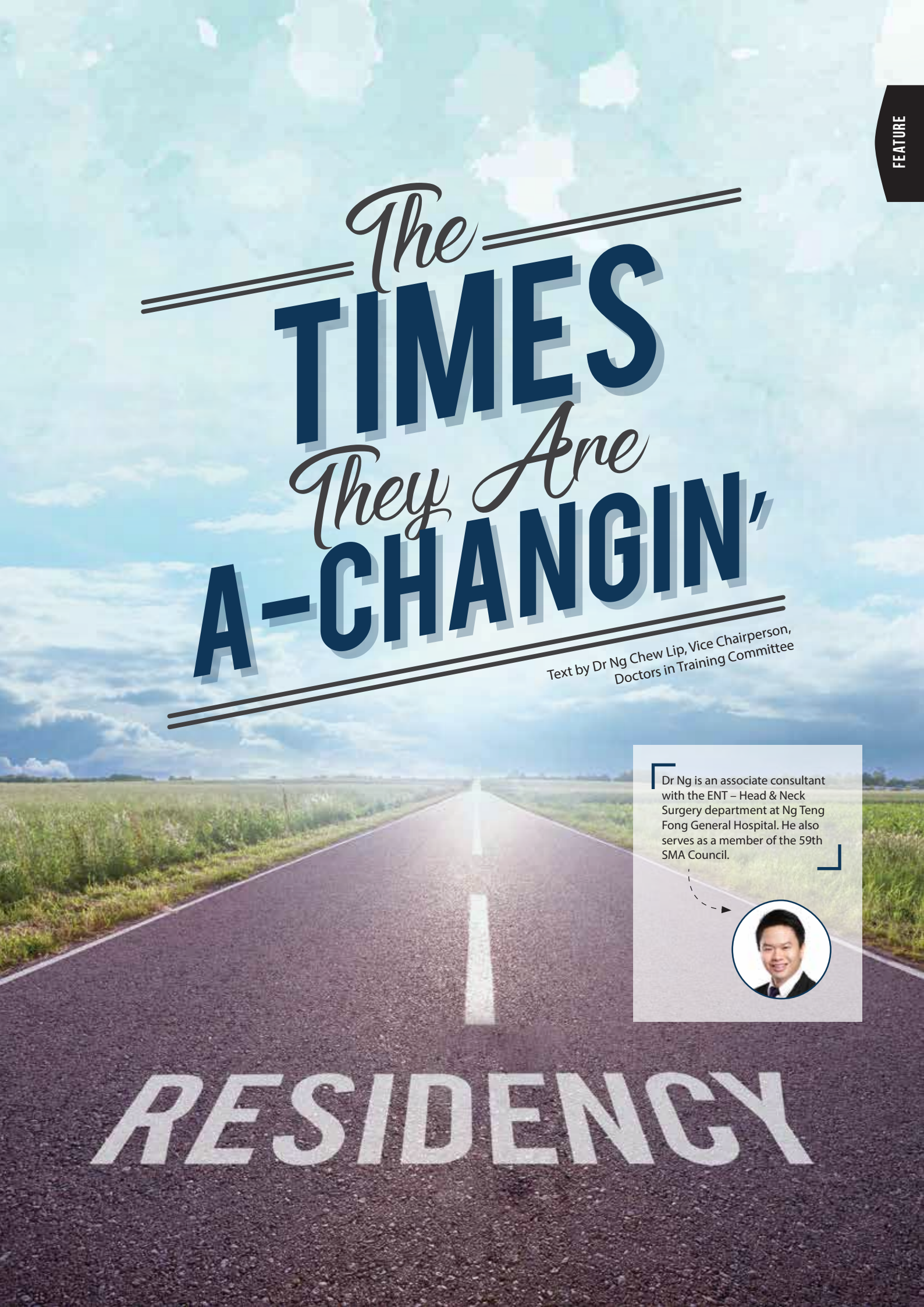
The TIMES They Are A-CHANGIN'

Text by Dr Ng Chew Lip, Vice Chairperson, Doctors in Training Committee



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When the changes in the postgraduate medical education (PGME) system took the medical profession by storm in 2010, an old song by Bob Dylan (one of the greatest lyricists in my opinion) came to mind:

"Your old road is rapidly agin'.

Please get out of the new one if you can't lend your hand

For the times they are a-changin'."

The times have certainly changed since 2012, when I last wrote about the residency system in *SMA News*. Significant resources had been invested, entire systems were transformed, examinations were scrapped and new ones implemented. Those who rode the education wave made successful careers as educators and the early batches of residents have graduated. Eight years after the first batch of residents were admitted into the Accreditation Council for Graduate Medical Education International (ACGME-I) residency system, let us take stock of the PGME scene.

Education structure

The transformation has been significant. All residents now log duty hours, cases they manage, education hours and any other minutiae of daily life into a software system. Leadership training, educator training, research and administrative training, awards and feedback have all been built into every resident's training portfolio. The documentation can be a gruelling chore for both residents and faculty, but it allows for tracking of activities and justifies decisions made on the residents' grading and progress. A sizeable team of administrative staff now supports the residency office and faculty. The notion that there needs to be a balance between service and education for residents is now well accepted by faculty and residents. There is an attempt, with varying success, to protect teaching hours for residents and faculty. Residents' feedback on faculty and vice versa are taken more seriously. Training progression, retention, remediation and termination are conducted through a rigorous and documented process. Checks and balances are in place. American in-service examinations have become part and parcel of residents' lives and Singaporeans are beginning to game it (no surprise there). In just two years' time, we would have done enough in-service examinations to compile the first TYS (Ten Year Series)!

Educating the educators

With the strain of having more trainees in the system, and to meet the standards imposed by the ACGME, some clinicians were streamlined to become clinician-educators to educate more systematically. Education is no longer based on "see one, do one, teach one". The knowledge, skills and accreditation of this group of doctors were upgraded even before the first residents were chosen. Innumerable courses, conferences and formal training equipped our educators with internationally recognised skills to not just educate but to implement systems and structures to better educate. Education buzzwords such as "entrustable professional activities", "competency-based progression" and "faculty development" began to surface and propagate in local PGME circles. Every process, including teaching, feedback, evaluation, progression, remediation and accreditation, is now formally and systematically instituted and documented. To become a recognised educator, one needs to undergo training. A national system of staging and accrediting the training of educators is now being developed. Some educators will undergo more training than others, and to assume certain positions, one may have to be deemed adequately schooled in how to educate. There is now a Chapter of Clinician Educators in the Academy of Medicine Singapore. It is one of 13 Chapters in the Academy that includes the Chapter of Physicians and Chapter of Surgeons, giving clinician-educators recognition at the professional level. Professional qualifications such as the Master of Professional Health Education were implemented and recognised.

The combination of political will, investment of adequate resources and the pressing need to meet international accreditation standards brought about a systematic and effective upgrade of both our educators and our education system. Our educators are an asset that will remain and will continue to impact and nurture future doctors regardless of how the PGME system evolves. That, in my opinion, is the greatest positive outcome of the residency system.

Specialists and specialist positions

The number of specialists accredited by the Specialist Accreditation Board (SAB) increased from 3,867 in 2012 to 5,384 in 2018 – a whopping 39.2% increase in a mere six years. This figure does not distinguish between specialists trained in Singapore or overseas, and does include the current in-flight residents. The residency has completed one major objective – producing more

specialists. This dramatic increase in the number of specialists was planned centrally at the Ministry level based on projections of need; an ageing population with more complex medical problems, growing medical tourism and a more demanding populace mean an increased need for specialist medical care. The new hospitals needed specialists to staff them. Based on these projections, the alarm was sounded. The national resident intake ballooned, with the intake in some specialties more than doubled.

This is the testament to how efficient and resilient the Singaporean system is – you want more specialists, you get more specialists. Somehow, the medical profession is always able to absorb the jolt of systemic upheaval and rise to the occasion when needed. In 2017, however, another projection from the Ministry comparing the number of in-flight residents against the number of associate consultant (AC) positions available revealed an alarming discrepancy – there were not enough specialist positions available for the residents to fill! Some specialties were assessed to have over-trained by 100%. Being accredited by the SAB does not mean one gets an AC position. This is one very real problem that a proportion of the exited residents faced. (I personally know of friends who did not manage to obtain AC positions after exiting.) Some specialties in some hospitals have recently mandated that exited residents serve one year as a service registrar/service senior resident (SSR) post-exit before being considered for AC positions. Some departments have devised creative human resource manoeuvres in order to absorb the deluge of newly minted specialists, such as part-time clinical work, part-time research, or part-time positions at both a hospital and its affiliated hospital to lower the financial costs of having another specialist in the department. The alarm was sounded (yet again!) and residency positions were significantly cut down.

In-flight residents are understandably worried that there may not be AC or even SSR positions for them after they exit. The days when you exit and become an AC by default are over. Have no illusions; the supply-demand relationship functions in medicine like in any other industry. We are not immune to market (or regulatory) forces. Whenever residents talk about job prospects nowadays, a tone of pessimism is invariably struck, save for the lucky ones who have been promised AC positions. The truth is that many departments are full, especially those in the more established hospitals, and to squeeze out another AC position is difficult when the departments are expected to balance their books. Thus, many a times, it is left to luck, opportunity and tampering expectations.

The situation where there are more trained specialists than specialist positions has also affected the perspectives of current medical students. Anecdotally, when I speak to medical students rotating through my department, I have found that a much larger number of them, as compared to the past, do not intend to specialise. When asked why, the reason is usually that "specialist training positions are dwindling and there may not be jobs even after exiting". The other reason for the shift in medical students' interests away from specialist training may be the promotion of holistic medical training by the Ministry to better manage the complex medical conditions associated with an ageing population, rather than specialist training which is perceived to be narrower in focus.

The era of coordinator and integrator training

Former Senior Minister of State for Health, Mr Chee Hong Tat, mentioned in his speech on 30 September 2017 that the residency system was being reviewed. Mr Chee said, "We have to be honest and acknowledge that while the residency programme has its advantages and good points, some of the outcomes have not been as positive in practice as what we had originally hoped for." This signals a watershed in the Ministry's approach to the residency programme. Changes are being implemented, including delaying earliest entry into residency at postgraduate year (PGY) 2 or after housemanship, decreasing the number of residency positions, centralising the residency programmes for some specialties and delaying overseas fellowship sponsorship till two years post-exit. Continued accreditation by ACGME-I has been called into question but a recent conversation between the Director of Medical Services and the SMA Doctors in Training Committee suggests that the Ministry is of the opinion that international benchmarking of our training programme is beneficial and that although the benchmarking model is being reviewed, the ACGME-I will likely remain involved in the PGME scene.

Having limited human resource, Singapore has always been deliberate in determining how it trains and deploys its manpower. PGME in the near future will be directed to producing doctors who can meet the perceived needs of the ageing and increasing population. If the past decade was focused on specialist training, the focus for the next decade may well be the training of the coordinator and integrator. The view by the Ministry is that an elderly patient has more complex medical issues than a younger one, with a different set of needs. Coordination of care becomes important. The general medicine physician or geriatrician, who is the coordinating physician, may be seeing the octogenarian in the ward for urinary tract infection, but will also be referring him to ENT for impacted ear wax, to the neurologist for Parkinson's symptoms and to the rehabilitation physician for functional decline. Palliative care will become more developed as more specialists are trained to provide end-of-life care for the elderly. There may even be a case for each specialty to develop a geriatric subspecialty or programme.

Apart from care coordination, the vertical integration of care, or transition

of care between hospital and the community, has been in focus, with various system-integration programmes such as Regional Health Systems and Primary Care Networks being rolled out. More family physicians who can contribute to these integrative health systems are needed. Acute hospitals are strained by the high workload, evidenced by the very high bed occupancy rates, in part due to the ease of access to acute specialist care and a healthcare financing system that assures minimal out-of-pocket payment once you are hospitalised. In theory, with stronger and more integrated primary and secondary care, some of the less acute conditions can be managed outside of the acute hospitals. However, the primary care provider must be trained and willing to handle these conditions and the patient must have enough confidence in the primary care system to not turn to the A&E at the first sign of anything vaguely serious. Decanting care to the community is elegant in theory but execution is a challenge in a complex system like healthcare. Training healthcare providers who can enable this process is one aspect of implementation.

The skill sets needed for this coordinative-integrative system to run smoothly are system-based practice skills, to borrow a term from the ACGME core competencies. The training of doctors, both specialists and generalists, who understand the systems-based concepts and healthcare economics, and can navigate the system, will become increasingly important. There are also plans for a significant increase in the number of polyclinics in the near future. This represents a major change in how primary care will be utilised by Singaporeans. With better training and, hopefully, more time with each patient, the polyclinics' roles have to evolve and they must be equipped to manage more complex cases. A large number of GPs and family physicians will be needed to staff these polyclinics. While specialist positions are saturated, there will be more positions available to young doctors for community and family medicine in the near future, and medical students are acutely aware of this.

Concluding words

Over the past decade, the PGME landscape has undergone a major transformation with the adoption of the ACGME-I residency system. As the PGME system is being reviewed, we can expect more changes to be implemented. Having immersed ourselves in both the American and British systems, we have seen the pros and cons of both and hopefully we can retain the positive aspects of each and modify the PGME model to better suit the local context and its needs. We hope that policymakers will consider in earnest the long-term career prospects of junior doctors and medical students in their decision making and adopt a consultative and collaborative approach with the medical profession to create a better healthcare system. Regardless of the prevailing system, the educators who have put in their heart and soul to make medical education their priority amid the uncertainty and changes should be honoured and their products will, I believe, make them proud.

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DID YOU KNOW?

The SMA Doctors in Training (DIT) Committee was formed in **2012** to provide a voice for all local doctors in training

Prior to that, it was known as the **Young Doctors Sub-Committee**

Leadership and representation on issues of importance to DITs is the key purpose of the Committee

The current *SMA News* Editor **Dr Tan Yia Swam** was the first SMA DIT Committee Chairperson

The first ever meeting that the SMA DIT Committee had **with any standing Director of Medical Services (DMS)** was with A/Prof Benjamin Ong on **25 May 2018**

The current SMA DIT Committee comprises representatives from **all 3 sponsoring institutions**

There are **3** SMA DIT Committee meetings every year

To view SMA DIT Committee's latest works, including key points from our meeting with DMS A/Prof Benjamin Ong on 25 May 2018, please visit *http://bit.ly/smaditcomm*.