

Residency Programmes in Singapore—Challenges Ahead

Boon Leng Lim, ¹MBBS, MMed (Anaes), FAMS

Transitioning from the specialist training system of the United Kingdom (UK) to the Residency system of the United States of America, Singapore¹ is in a position to evaluate both and integrate their best features into one uniquely Singaporean system that addresses the needs of healthcare services in the country.

We must find ways to overcome challenges in recruiting, training and retaining talent, integrating and transitioning between the old and new systems, and ensuring talented leadership in healthcare administration, clinical service, education and research. The following paragraphs outline my suggestions to address these difficulties.

Recruit

With the rising demands on the healthcare system, we should recruit more medical graduates into Residency. Ministry of Health Holdings has been actively recruiting both Singaporean and foreign doctors who have graduated from the best universities in the UK, Ireland and Australia since 2000, as well as China from 2010. Those studying in Singapore Medical Council (SMC)-accredited medical schools would thus have the option to apply for Residency training in Singapore. Another possible move is to make acceptance into Residency competitive by taking applications from graduates of non-SMC accredited medical schools who have passed a rigorous examination (e.g. the United States Medical Licensing Examination). This will ensure that we attract a bigger pool of the best candidates.

Train

By combining the housemanship and medical officer (MO) years into the first year of Residency (R1), the number of years required to train specialists has been reduced. However, Residency Programme Directors (PDs) now lack opportunities to get to know applicants, and the applicants may have limited understanding of the specialties they choose, possibly contributing to attrition in Residency Programmes due to mismatched expectations.

Thus, I propose to replace housemanship with a mandatory Accreditation Council for Graduate Medical Education International (ACGME-I)-accredited Transitional Year (TY) for the top 60% to 80% of performers in the medical school cohort. This TY will provide structured learning in the 6 competencies (patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice) and opportunities for regular evaluations of the physicians' abilities and attitudes.

Interviews for different training programmes can be conducted by the respective sponsoring institutions (SIs) near the end of the TY training. By this time, the residents would have gained basic clinical skills and a better appreciation of the specialties, while Residency PDs would have 3 rotations' worth of clinical performance reports with which to evaluate each candidate. The TY can be credited as R1 for accepted applicants, which would allow possible acceleration of training for the top 20% of performers. Applicants not accepted into Residency would join the MO pool to improve their clinical skills further before next residency application.

Internal Medicine residents receive an initial broad, foundational training that includes subspecialty rotations. I propose that surgical subspecialties adopt a similar system, where accepted residents start with a 2-year Foundation Training in Surgery, which includes rotations through all surgical subspecialties. At the end of the second year, the SIs would interview residents for their desired subspecialty, and those who are not selected can become Residential Physicians (RPs). Thus, all candidates entering a surgical subspecialty are trained to a certain level of proficiency, and the additional evaluations performed during Foundation Training ensure only the best are accepted.

I also suggest that we take full advantage of the use of simulation for training in surgical procedures. It is in the best interest of patients for residents to hone their skills in an environment where they can make mistakes without serious repercussions, and learn from them before they

¹Graduate Medical Education Office, SingHealth Residency

Address for Correspondence: Dr Lim Boon Leng, Designated Institutional Official, SingHealth Residency, No. 2 Jalan Bukit Merah, Block 1, Level 1, Singapore 169547.

Email: lim.boon.leng@sgh.com.sg

are allowed to perform procedures in the clinical setting.

Some specialties have smaller capacity in terms of clinical volume than others; I propose that Residency Programmes that have intakes of less than 5 residents per year be converted to a national programme, for better training of specialist and more efficient use of the different SIs' resources.

At the end of their training, residents take their Specialty Certification Board examination. Those who do not take or do not pass the examination are considered Board Eligible, while those who pass are considered Board Certified (and become Consultants). About 20% of each graduating cohort is expected to become Board Eligible, and as their Residency training remains valid, we could allow them to work as RPs (analogous to MO specialists in the old system). They would then act as junior specialists at Regional Hospitals, reducing the manpower crunch at tertiary hospitals. Specialists who wish to pursue careers as clinician-scientists can work as RPs in clinical practice so that it is easier to take time-off to pursue research.

Retain

There is a need to capture promising students early and recruit them into Residency. We should allow fast-tracking of the top 20% of each graduating class into specialist training, and enable quicker promotion during Residency, provided the trainees have demonstrated the requisite skills and knowledge for advancement. We should also assist those inclined to pursue a clinician-scientist² or clinician-educator track by reducing the burden on them to put in extra time for required training.

National Leadership Development

Finally, potential leaders should be identified early by screening the top 5% to 10% of each Residency Programme for leadership potential, and providing them with national leadership training.³ Today's Chief Residents will be tomorrow's Chairmen of Medical Boards and Heads of Department, and this process will facilitate early communication among future leaders. Furthermore, at the national level, leadership at the Ministry of Health (MOH) and SIs should engage the Chief Residents from all

programmes from all SIs to discuss healthcare-related issues. The Chief Residents can engage in 2-way communication with national planners at MOH, giving feedback as well as suggesting ideas for implementation. This would address the current disconnect between top leadership and those on the ground.

Education and training provide the foundation in building a world-class, sustainable healthcare system in our country. To address the challenges that the Singapore healthcare system faces today (such as the shortage of healthcare professionals for an ageing population), there must be a concerted effort from faculty and senior doctors, the SMC, the Specialist Accreditation Board and Joint Committee of Specialist Training, SIs (SingHealth, National Healthcare Group, the National University Health System) and medical schools (Yong Loo Lin School of Medicine, Duke-NUS Graduate Medical School, and Lee Kong Chian School of Medicine) to support Residency Programmes in Singapore.

REFERENCES

1. Huggan PJ, Samarasekara DD, Archuleta S, Khoo SM, Sim SHS, Sin CSP, Ooi SBS. The Successful, Rapid Transition to a New Model of Graduate Medical Education in Singapore. *Acad Med* 2012; 87:1268-73.
2. Salto-Tellez M, Oh VMS, Lee EH. How do we Encourage Clinician Scientists in Singapore? *Ann Acad Med Singapore* 2007;36:879-880.
3. Doughty RA, Williams PD, Seashore CN. Chief Resident Training. Developing Leadership Skills for Future Medical Leaders. *Am J Dis Child* 1991;145:639-42.