

By Prof Chee Yam Cheng, Editorial Board Member

Specialist Training in Singapore

BACKGROUND

Specialist training in the Singapore public healthcare system has been a structured exercise since the previous century. When the Ministry of Health (MOH) decided in the late 1970s that medical manpower was a crucial success factor for Health for All (World Health Organisation slogan for 2000) and the Health Manpower Development Programme (HMDP) was initiated in the early 1980s, the training of specialists followed a sequenced programme determined prospectively by the Specialist Training Committees (STCs).

In the 1970s, the Academy of Medicine published its criteria for specialists to be on its Specialist Roll. This identified 35 specialties and did not consider Cardiology, Neurology, Dermatology, and so on, as subspecialties of Medicine but as specialties within their own rights. Nonetheless these subspecialists have common training at the basic level in Internal Medicine before branching off into their own specific training tracks under their own STCs.

When the Specialist Accreditation Board was formed and its Specialist Register was started, the Specialist Roll in effect became the Register but now with full legal backing.

TRAINING PROGRAMMES

We inherited the UK based system of training specialists. In the 1960s, the Australian Colleges helped trained our specialists. Either our doctors went to Australia and/or their College faculty came here to conduct courses and exams. However, in the 1970s, when the first of the local Master of Medicine (M Med) degrees were conferred by the University of Singapore (which in 1980 became the National University of Singapore (NUS)), the formalised system of training was implemented.

This consisted of two phases, basic and advanced. NUS was involved in the basic specialty training (BST) including the postgraduate exam (M Med). The Academy of Medicine was responsible for the advanced specialty training (AST) through implementation of requirements for its Specialist Roll and Fellowship of the Academy.

Thus for most specialties, it was three years in BST and three to four years in AST. There was no progression from one to the other without fulfillment of two criteria, among others. These two criteria were, one, adequate and relevant postings (experience in different departments and disciplines) and two, passing the relevant postgraduate examination.

This has gone on for over 30 years now and when the HMDP allowed doctors to go abroad fully funded for training periods of up to two years, this period was often part of the AST. As Singapore progressed and its specialist training programmes stabilised and matured with more specialists trained, willing and able to train even more doctors locally, the need for long overseas HMDP diminished. Instead specialists were using the HMDP for subspecialty training and this benefited the local training immensely. So today the HMDP is usually awarded after the completion of AST except in specialties, disciplines or subspecialties where the need for an overseas stint is still necessary to complete the formalised, structured training programme.

Today we are also receiving foreign doctors who come to train with us. We have become the preferred training centre for doctors in this region. It has taken us some 30 years to achieve this and we are proud of this status.

21ST CENTURY

After the non-event of the Y2K bug, and after the devastating unexpected SARS outbreak of 2003, changes in the training of specialists have been implemented with two major objectives in mind. One was the shortening of training to below six years. This is in part driven by the location of the Duke University Graduate Medical School on campus at the Singapore General Hospital which started its first intake in August 2007. The other was the urgent need to produce more medical specialist manpower to serve the nation and the regions beyond.

The Duke Medical School graduates would be pretty much into their 30s upon graduation. And if their further specialist training took another six years or more, they would be over 35 years old



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before they started full practice as specialists. For graduates of the Yong Loo Lin School of Medicine, NUS, a six-year postgraduate training would age them to about 31 to 32 years of age. Remember that in the present day medical schools, there are more females than males. And surely we need babies more than we need doctors? The second reason is the urgent need to infuse more specialists into the system without compromising standards of training and practice. Patient expectations of doctors and healthcare have risen tremendously and working in the same old hurried way will not do.

And so was born the seamless structured training programme concept.

SEAMLESS TRAINING

The idea in seamless training is to do away with the break between BST and AST. This is especially true for those specialties that do Internal Medicine in BST, then branch into Cardiology, Neurology, Infectious Diseases, and so on, in AST. It is likewise for those doing General Surgery in BST, then pursuing Plastic Surgery, Urology, and so on, as AST. The break signifies the end of BST. The start of AST begins only after another competitive selection interview. In the past, the number of AST places was limited so some of those who had completed their BSTs had to wait longer for an AST position. Some never succeeded in getting this AST at all.

In the seamless programme, the appointment as trainee occurs just once, at the beginning of BST. The programme runs till the end of AST, culminating in the exit examination. There is no break in between. The intermediate postgraduate examination needs to be passed somewhere in this continuum of training. Let me illustrate.

For Internal Medicine, there are two tracks available to the exit examination. The usual track

is three years BST followed by two years AST. (The sixth year of training has been removed as the HMDP is done after completion of training. Further there is no provision for research experience in the two years of AST). The fast track is the seamless track and lasts four years (that is, one year shorter still). The intermediate examination is to be passed before the end of the third year. Otherwise the training period may be extended by another year. In both tracks, the exit examination is Internal Medicine.

Starting May 2008, at least two other specialties will go seamless. They are Dermatology, and Respiratory Medicine. At the initial interview, these STCs will appoint their trainees and the same STCs will track and monitor their progress until they sit for their exit examinations in Dermatology and Respiratory Medicine respectively. They will decide what intermediate examination is necessary.

What about those who chose BST in Internal Medicine and after completion decide to do Dermatology or Respiratory Medicine? The respective STCs will decide if and where these doctors can join their seamless programme.

CONCLUSION

We are in need of more specialists in Singapore. Foreign talent recruitment has not been very successful at the specialist level. Therefore our local training pipeline has to be increased in bandwidth. That alone is insufficient because we need more specialists in a hurry. Hence there is the elimination of wait time and administrative obstacles through the implementation of the seamless, run-through training programme. This must not happen at the expense of standards and quality. After all, the training credo in Singapore has always been, the next generation far better than ourselves today, the trainers and mentors. ■