

I was pleasantly surprised to hear about the impending changes to postgraduate medical training in Singapore. Change is not always easy, but always necessary. I guess as one who has been through both systems of postgraduate training (the Commonwealth, otherwise known as “British” and American), I might have something useful to share about my experiences.

My postgraduate training in both systems was not something I planned from the outset (as if five years of medical school isn't enough?). I had a pretty clear idea of what I wanted to do by my third or fourth year of medical school: Internal Medicine, Infectious Disease (ID) and Microbiology attracted me the most, and this decision was reinforced by mentors and teachers whom I met along my path of training. The flexibility of the local system meant that although I knew I was going to focus on Internal Medicine, I could still complete nine months of surgical rotations to gain some experience before I started on my specialty proper. I still remember when, as a first-year medical officer assisting a breast surgeon, we were asked what we wanted to do. My co-medical-officer replied, “Neurosurgery” which drew a lukewarm response of “Interesting...” I said, “Internal Medicine”, and there was a prolonged moment of awkward silence. Thankfully the patient was anaesthetised.

Initially, however, like most other Singapore doctors post-graduation, I had to navigate the complicated postgraduate training system, undergo National Service, and try to juggle work while studying for the MRCP at the same time. In the midst of doing all this, my mentors (Drs Paul Tambyah and Kamal Singh who had both trained in the US and knew I had a strong interest in ID), suggested I think about training in the US. The prospect of training in a different system was both exciting and initially intimidating. After all, like most Singapore doctors (or the rest of the world for that matter), we get a lot of our ideas about American medicine from shows like *ER*, *Chicago Hope* or worse still, *Grey's Anatomy* or *Scrubs*. I was also duly warned that I would be



HIV rotation at the Stroger Hospital of Cook County (Cook County Hospital)

Training in the US and Singapore

Journey of a final year resident

by Dr Shawn Vasoo

requesting CTs “left, right and centre” after my return. To that, a nephrologist, who had trained in the Cleveland Clinic and is currently working in the National University Hospital, made an interesting remark that waiting for the clinical sign of clubbing before picking up a lung malignancy might be a little too late!

In 2005, I applied for the “Match” which is similar to a giant MOPEX, and which all applicants in a US residency programme go through. I was a fourth-year medical officer then, nearly done with the MRCP, and was pretty comfortable working and carrying on with my training here. So, I wasn't terribly disappointed when I did not match initially (I applied to 20 programmes, interviewed at 3 and only ranked 2!). I decided to continue training in Singapore and declined several offers for an externship with a view to apply again for residency in the US. I completed my MRCP in the meantime. Towards November 2006, I was about to decide on a hospital to join for ID fellowship locally, when Dr Kamal Singh asked if I would apply again. I attended an interview and was accepted into a training position in the categorical Internal Medicine programme at Rush

University Medical Centre in Chicago. I started residency in July 2007, which will be followed by an Infectious Disease fellowship in mid-2010.

What were the things which drew me to training in the US? The first draw was that everyone I had met who had trained there (and who'd been in both systems) had very positive experiences and nothing negative to say. Secondly, I sensed the interest that these doctors took in the education and mentorship of junior doctors (in clinical education, research, and our ‘out of work’ lives). Education does not end with graduation, but is an ongoing process. To them, a trainee who turns out poorly is a poor reflection of the programme, and a trainee's success is also viewed as the programme's success. Thirdly, postgraduate training in the US is very structured. Rotations in general medicine or various subspecialties usually last a month with a ‘core amount’ of in-patient and ambulatory experiences that each trainee should undergo. All these (including welfare issues like work hours) are assessed by an independent body called the Accreditation Council of Graduate Medical Education (ACGME). Additionally – while it's about balance

and some may differ in opinion – the emphases of medical education are different. A feeling I had while navigating through the MRCPs was that I was accumulating knowledge in multiple esoteric conditions, which might be better left to the specialist and it might be more edifying to the patient if our initial postgraduate training placed more emphasis on “bread-and-butter” matters.

Fourthly, because medicine is rapidly evolving, research and evidence-based medicine plays an important day-to-day role in medical decision-making, even at a junior level. For example, when requesting a “D-Dimer” or a CT-PE protocol during residency, we would be made to think about pre-test probabilities and which would be a more appropriate examination. Avenues for scholarly activity and research for those so inclined are encouraged and integrated into our training. Electronic access to journals is readily available from work or home. Fifthly, the work environment and culture have also been draws. Attendings are easy to approach and the work environment is less hierarchical. Education is emphasised over clinical service, residents are viewed as trainees there to learn and not as “scut monsters”, otherwise known as “clerking machines” or phlebotomists. Resident work hours are scrutinised – Internal Medicine residents have a 70-hour work week cap and interns are limited to seven admissions a night. I’m also to make sure my intern gets home on time. Clinics are usually capped at six patients each session, with every patient seen discussed in detail with an attending. Because of these differences, while before it was easier for me to curl up with *The New Paper* rather than the *New England Journal of Medicine* after a long day at work, I’ve found opportunities to be interested again in reading and in my own medical education. My Singaporean friends usually gasp when I mention this (I used to see 30 patients in one morning alone on a busy clinic day!) but then again, we spend more time with the patients, who generally ask more questions, and coordinate all aspects of their primary care and health maintenance, in addition to staffing the patient with our regular

clinic attending and also spending more time in careful documentation. This definitely enhances the educational experience. These aspects are probably possible largely because of better doctor-patient ratios, which I believe is something Singapore has recognised and is moving towards. Happier doctors definitely make for happier patients and working environments. A typical Internal Medicine team comprises the senior resident, the intern(s) and medical students while the attending and residents play an important role as teachers and role models to ensure that the intern and medical student have as educational an experience as possible. The team also takes ownership of each patient they care for, from admission to discharge, entering all the orders (attendings do not have the right to do so!) and actively formulating plans for the patient.

integrating into practice in the US system has been much easier than I expected, and that the system recognises a good doctor when it sees one. It is no wonder that many doctors choose to stay on after they complete their training in the US. As Singapore also sees similar changes, where an increasing number of foreign-trained physicians seek postgraduate training locally, we will do well to train and retain the best (both local and international graduates), and making our training as cosmopolitan as possible.

I am grateful for the excellent undergraduate education I received at the National University of Singapore, and am also thankful for the opportunity to have experienced postgraduate training in both systems. I think our current postgraduate training stems from a wonderfully rich tradition, aspects of which we will do well to retain, at the



Intern year – my classmates take me out to eat at the Penang Restaurant in Chicago

Lastly, residency has been truly a “melting-pot” experience; whilst most of my classmates are US graduates, I’ve also worked with a smattering of co-residents from various backgrounds (Brazil, India Panama, the Philippines, Malaysia, and so on). I have a few classmates who are in their 40s and previously were not in Medicine. Some are in combined programmes like medicine-psychiatry or medicine-paediatrics. All these definitely enrich the residency experience. I have also been told that in the US, it’s ok even if you’re “green in colour”, as long as you are able to get the job done. In this respect, I’ve definitely found that

same time embracing the changes not only in system, but also the mind-sets with regards to the ever-evolving landscape of medical education and medicine itself. This will take time and there will be bumps along the way – but the end product will be something we can proudly call (at the risk of sounding clichéd) – uniquely Singaporean. **SMA**



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