MY US POSTGRADUATE EDUCATION

By Dr Desmond Wai

Much as been said lately about the US postgraduate specialist training that will be taking place in Singapore. Like any new policy, some are excited while others are worried about its implementation. I hope to share my personal experience during my HMDP in 2002 to help young doctors here better understand the US system.

Disclaimer

The United States is a big country and my experience does not necessarily reflect the overall system. This article merely shows my personal experience.

Daily inpatient ward round

I worked as a Fellow, something like a Registrar, during my HMDP at the Department of Gastroenterology, University of Michigan Medical Center. The inpatient ward round started at 0730 every day. By the time I arrived, the Resident (equivalent to Medical Officer) would have completed the round, and would be waiting for the arrival of the Attending Physician (equivalent to Consultant).

The staff room was where the ward round started. The Resident would present all the cases as if in a long case exam to the Attending. More importantly, the Resident would say what he planned to do for treatment. The Residents took ownership of the patient, and the Attending was there to monitor and to guide them.

From my observation, the Residents were intelligent and highly-motivated young people. They would spend hours surfing websites like PubMed, MD Consult and UpToDate to learn about the latest treatment for all conditions they encountered in the ward. After spending 30 minutes in the staff room discussing treatment plans for all the inpatients, we would then go to meet them. The Attending had to physically examine and speak with each inpatient daily. A mere "walk round" by the Attending was not acceptable and he/she also had to personally handwrite onto the case notes daily. The Resident could not just write "S/B Prof, agreed" in the case notes.

In addition to the morning round, we usually made another evening round by 5pm to review all results and new patients.

Outpatient clinics

I ran three clinics every week on general Hepatology, liver transplantation, and inflammatory bowel disease (IBD). The clinic session was as closely-supervised as the inpatient ward round. I would spend 20 minutes going through electronic medical records, and reading up on the subject on the Internet, then meeting the patient. After that, I would return to the staff room to discuss the case with the Attending. Again, the whole idea was for me to tell the Attending what I thought the problem was and how I planned to solve it. The Attending would then meet the patient with me – by law, the Attending must physically speak with, and examine each patient. I normally saw 4-6 patients every session, as each case would take up about an hour to complete, but was discussed in great depth.

The hospital was a tertiary center so we received referrals from other gastroenterologists and primary care physicians. There were no walk-ins and we hardly saw any simple cases like inactive hepatitis B carriers or uncomplicated abdominal pain.

In what way is the US system better?

(1) It is an Attending-based system and every patient must be physically examined and spoken to by an Attending Physician every day. All activities of the Fellows and Residents are supervised by the Attending. Procedures like endoscopy are done by endoscopies the Fellows but the Attending must be present during the procedure.

The problem with the Singapore system is that we call for help when we think we have a problem. Sometimes, help is not within reach. But more importantly, many times our trainees do not even realise what he/she does not know and as a result, do not call for help.

(2) I saw many uncommon liver diseases and IBD cases during my HMDP training, as the University center was the tertiary center where patients were referred to by community gastroenterologists. Because of this, I was exposed to a greater variety of cases during my one year HMDP in the US, than my three years as Registrar in Singapore.

(3) The Fellows and Residents are highly-motivated and intelligent. I gathered that they were selected out of a big pool of applicants and only the best were chosen.

(4) There was tremendous institutional support to make training a priority. Besides the free flow of pizza and soda during academic meetings, the University set many rules and bars for teaching. Each Attending Physician is appraised by the Residents and Fellows at the end of each posting and he/she must score a satisfactory grade in teaching. Verbal abuse or even sarcastic comments are strictly forbidden. My mentor was the head of Hepatology and she held multi-million NIH grants. Yet she also had to do her fair share of teaching. She could not just ask her juniors to take over teaching duties.

Upon admission, each patient is given a patient-handbook. On page one, it states, "Your resident physicians will be the doctors who write orders and make decisions related to your care under the direct supervision of your attending physician." Patients treat the Residents as their doctors, and do not make comments like "I only want to speak with the Consultant."

In what way is the Singapore system better?

(1) The US system is expensive. A doctor colleague of mine fainted, fell and fractured his fibula. He was promptly attended to by a Resident and his Attending at the Emergency Department. He had some blood tests, a CT brain scan, and an x-ray of his leg done. The fracture was diagnosed and a specialist plaster nurse put on a nice plaster for him. The whole process was completed without any delay. His final bill: US$2,800. (Back in 2002, the Singapore-US dollar exchange rate was US$1=S$1.80). The care was good, supervised, and prompt but would you rather pay S$75 at a local Emergency Department and be attended to by a Medical Officer?

(2) The cases are too skewed. Fellows and Residents who are trained at a tertiary medical center may be too used to complicated cases, and are at risk of over-investigating straightforward and simple cases when they are posted back to the community.

A/Prof Teoh Eng Kiong (second from right), currently the Chief of Medicine at Changi General Hospital, was also a former Fellow under my mentor, Dr Anna Lok (centre)

Conclusion

To sum up, there are many advantages in the US postgraduate education system. I personally felt that I learned a lot during my one-year attachment there. Local graduates would feel at ease if they were trained under the US system.

What I am worried about, however, is that we do not copy the whole system, but bits and pieces, and do not reap the full benefits of it.

I remember when I was a houseman 16 years ago, I did about 5-7 night calls per month. During each call, besides the 10-20 new admissions that we had to clerk, we had to give IV medications at 8pm, 12 midnight, and 2am. Back then, the IV Ampicillin 500mg 6-hourly and Gentamycin 50mg 8-hourly combination was a popular regime and all IVs had to be given by doctors (not nurses). We usually got a short break from 5am to 7am but one particular Consultant loved to order blood tests at 6am. I heard from my seniors that he was US-trained, where all lab work was done at 6am so by the time the doctors did rounds at 8am, the results were ready. It was good for the Consultant and the patients I suppose, but bad for the houseman like myself.

During my HDMP in US many years later, I gathered that yes, blood tests were done at 6am on the patients so results were ready by 8am. But all venepucture were performed by a 24-hour phlebotomy team, not the interns on-call.

When we copy the US system, we must copy the whole set, including the rationale and the spirit, and we must be sure we have the logistic support to accommodate a new system. SMA

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