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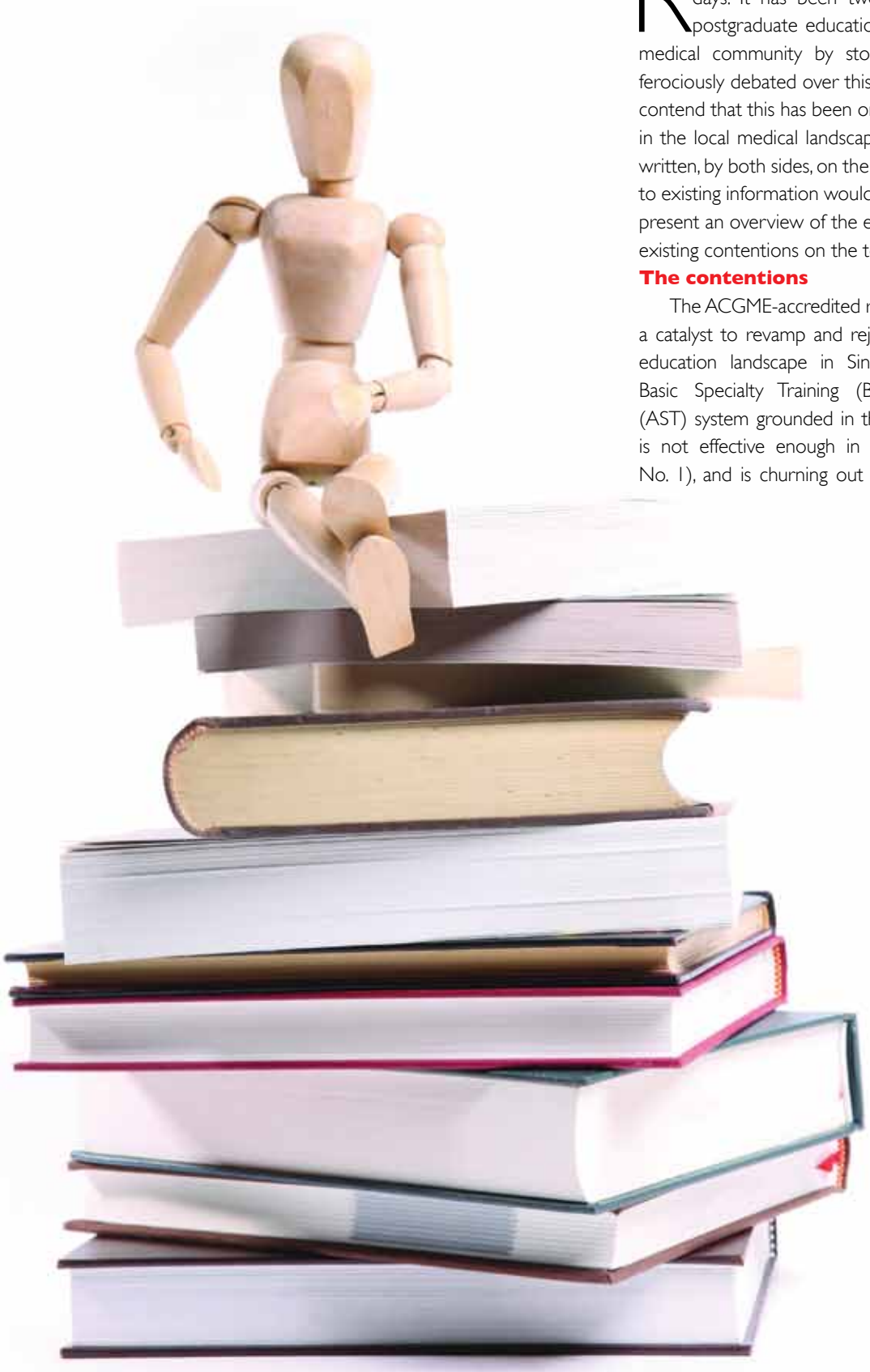

"Residency" seems to be on everyone's minds these days. It has been two years since the American-style postgraduate education training system swept the local medical community by storm. Supporters and critics have ferociously debated over this, and it is not an overstatement to contend that this has been one of the most momentous events in the local medical landscape in recent years. Much has been written, by both sides, on the residency system, so to add details to existing information would be superfluous. In this article, I will present an overview of the events that have transpired and the existing contentions on the topic.

The contentions

The ACGME-accredited residency system was introduced as a catalyst to revamp and rejuvenate the postgraduate medical education landscape in Singapore. Purportedly, the existing Basic Specialty Training (BST)/Advanced Specialty Training (AST) system grounded in the British way of specialist training is not effective enough in producing specialists (Contention No. 1), and is churning out specialists at a rate that is unable

Residency

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to catch up with the increasing size of our population that is also ageing rapidly (Contention No. 2). In addition, it has been claimed that there is inadequate supervision of trainees, evaluation and documentation of training requirements and outcomes (Contention No. 3). Teachers and mentors teach out of goodwill with no monetary rewards or protected time, and with the increasing administrative and clinical loads, the enthusiasm for teaching is flagging (Contention No. 4). Then the authorities decided it was time for a shake up. The Americans were brought in, and we adopted their education system almost entirely (Contention No. 5), from curriculum writing, training regulations, standards of resident supervision, training outcome measures and documentation, examinations to organisation of training faculty. The healthcare systems in both countries differ significantly and implementation proved to be no simple affair. We only bring in a system when it is believed to be superior to our existing system. A significant number do not believe that is so. Therein lies Contention No. 6.

Execution was swift. The change was abruptly implemented one year before the first batch of Duke-NUS Graduate Medical School students graduated, bolstering suggestions that the system was brought in to allow the American-trained Duke-NUS graduates to continue their training in the US system seamlessly (Contention No. 7). The batch of M5 students from Yong Loo Lin School of Medicine (my class), who were to become the pioneer batch of residents was informed of the edict that we would have to apply for residency, three months before our final MBBS exams, again fuelling rumours that we were the guinea pigs to test out the system. We were told that resident positions would be ring-fenced for us, and a certain proportion will be reserved for medical students every year. Contention No. 8 – why are medical students given priority over more senior house officers (HOs) and medical officers (MOs)? Entrants to residency can be fresh from medical school, with little actual clinical experience and with the shortening of training under the ACGME system, will our future specialists be adequately trained? Would medical students and HOs know which specialty is suitable for them (Contention No. 9)?

Under the new system, residents stay in one "cluster" or "sponsoring institution" (SI) and do not rotate like in the former system (Contention No. 10). The proponents believe that this will lead to more ownership and supervision of residents. The opponents argue that residents will become myopic, do not see the best practices of other hospitals and become silo-minded. Clusters embrace this because from an institutional point of view, they can better imbue residents with their institutional values, foster loyalty and because each SI believes in its capability to train the best residents. Residents are given protected time and can only work 80 hours a week. That fuels Contention No. 11 – with service load remaining the same and with fewer man hours put in by residents, will non-residents have to shoulder the remaining load? Also, will we train specialists who are imbued with a sense of entitlement? Some AST programmes were shut down and the unfortunate few registrar-level trainees who did not manage to secure AST positions were given an option to stay as service registrars for life, exit the system or start as first year residents. After their years of service, has the system failed them?

The above is a non-exhaustive hotchpotch list of contentions, facts and rumours. Contentions stem from differing opinions on a subject. It is not my intention to provide a rigorously researched article with a list of source quotations. I present the raw backdrop and atmosphere at the inception of the residency system. And this was the tumultuous and uncertain environment into which residency was born.

Two years on, how has the fledgling residency programme fared?

The current state of affairs

There are now more than 500 residents under the ACGME programme across three SIs. They are supervised, trained and counselled by faculty mentors who have up to 50% of their time (0.5 full-time equivalent) paid for by the residency programme to teach and supervise their residents. Faculty members' key performance indicators are pegged to their residents' and programme's performance. They attend courses on how to teach, assess and mentor. SIs pump in more resources and take a more proactive approach to training their future specialists. Residents are given protected time to study and attend courses. The curriculum is more holistic, covering medical knowledge and skills, professionalism, ethics, research skills, biostatistics and management lessons. Every posting is planned, with specific goals and objectives laid out clearly at the start of the posting. There are resident representatives in all major committees under the Graduate Medical Education Committee, the governing body for residency in each SI, giving residents a voice in their own education. Opportunities are provided for residents with research and academic inclinations to pursue master's and PhD degrees during the course of their training. SIs supplement residents' Personal Training Fund (PTF), so residents have more resources to purchase books and attend courses. A holistic evaluation of residents' progress and competencies including 360 degree evaluations by senior and junior doctors as well as allied healthcare workers, is in place. This overlapping of assessment tools has led to more objective and accurate evaluations of residents. Residents also evaluate the faculty. Courses attended, examination results, procedural skills and rotation evaluations are

all documented meticulously and every promotion or delay in promotion of residents can be justified. All in all, a comprehensive structure for teaching, evaluating and empowering residents has been put in place in a short span of two years.

What about non-residents? The BSTs may feel they are second class citizens because they are not "owned" by any of the SIs they rotate through. They do not enjoy some of the perks the residents enjoy, like representation in hospital-wide committees and PTF top-ups. They fear that the "best" cases are given to residents in the operating theatres, and the "best" research projects are given to residents who can stay in the institution to complete the projects. The HOs and MOs not in BST or residency may feel they are third class citizens. It is increasingly difficult to secure postings in the larger tertiary hospitals, where training opportunities and casemix are perceived rightly or wrongly to be better, as the positions are staffed by their own residents. They may not get their choice of postings as residents are given the first cut and BSTs come second. As such, they drift further away from getting traineeship. In this real or perceived discrepancy in treatment and opportunities exists tension and angst. To be fair, the SIs and most departments have made it a principle to open up most educational opportunities, including courses and teaching sessions to all doctors and not just the residents, and to evaluate non-residents the same way as residents. But there are still many tangible and intangible benefits to being a resident. One can understand why there is a big rush amongst medical students to enter residency the moment they graduate, leading to early electives (from the first year), to make contact with departments they wish to join and doing many research projects to beef up their CV. Structure drives behaviour.

Often, the opponents of a change oversell the benefits of the old and underrate the new, while the proponents may oversell the new and underrate the old. Whatever it is, the jury is still out. We will never know until the products of the new system emerge, and to take an even longer perspective, the products trained by these products. The residency system will be judged by the quality of its products. I recall an anecdote about the Chinese Premier Zhou Enlai. When asked about the results of the French Revolution of 1789 by US President Richard Nixon, he replied, "It is too early to say." And that was almost 200 years after the Revolution! The anecdote was widely used to demonstrate the timeframe Chinese leaders employ when they make strategic assessments or decisions. Much of the current debate has been on the immediate impact of the transition. Can we be farsighted like Zhou? No matter what, we will only know if we succeed or flounder years later.

What we can expect is that the new system is here to stay, though there are sceptics who believe it will implode and we will return to the old system. The entire residency movement has gained a momentum of its own, which is no longer solely top-down. A huge momentum is being generated from the ground as more and more senior doctors become faculty members and junior doctors become residents. Those on the bandwagon have their training, careers and even legacies staked on it and when you're on it, you tend to support it. Resources have been put in, and a new education structure that is not inferior to the old is already in place. It will take a lot to halt the steam locomotive that has already left the station. The system may very well stay.

With such heated debates, it is evident that there are pros and cons to both systems. It is not simply old versus new. A person taking a purist stand, swearing by one system and condemning the other is like having homonymous hemianopia. Transcending the differences between the old and the new, taking the best elements of the two great systems, and creating a unique Singapore model for postgraduate medical education, suited to our national context (and even better if we can export it like our primary school textbooks in future) is probably the way to go. A world class medical education system is a key component of Singapore's ambitions to become a medical hub. We have heard much from both sides trying to prove their superiority but have not seen much discourse on distilling the good from both systems, or rather, what is most beneficial for Singapore. Perhaps some debate and discussion on that may be more constructive and less divisive for the medical community. Much of the angst has come from the way the new system was implemented and the discrepancy in treatment between residents and non-residents. We will do well to address these issues.

Despite the painful birth of the residency programme, it has generated a renewed enthusiasm and interest in postgraduate medical education, which is spilling over to undergraduate medical education. A better structure and a lot more resources have been injected into postgraduate training, benefiting both trainees and educators. As a doctor, a resident, a future patient and a Singaporean, I pray for a successful postgraduate training programme for Singapore. At the core of the mission of medical education is to produce competent specialists and generalists to serve the sick and infirm. That has not changed. The system must continue to evolve and improve to better fulfill this aim. SMA

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