

The life of a urology trainee in Singapore

BY SHUM CHEUK FAN

Despite the political and cultural differences between the United Kingdom and Singapore, the quality and nature of the medical training systems remain uniquely similar. It will come as no surprise to those of you who have either worked in Singapore (or alternatively worked with colleagues who have trained in Singapore) that the quality of its graduates are world class and second to none. There is still that feel of the 'old-style' senior registrar about current senior trainees. Here Shum Cheuk Fan reflects on the move away from the 'traditional' UK training system – in the same way as Modernising Medical Careers (MMC) and run-through programmes in the UK have radically changed the face of training here – requiring trainees to commit at increasingly earlier stages to long-term career decisions. Shum, like many of his UK counterparts, can only speculate as to whether these changes are for the long-term good. What is clear is that the system, which stretches its best and most able graduates, is able to prepare them for distinguished careers in a system, which sees Singapore as a regional leader in the provision of cutting-edge healthcare provision.

Tim Lane, Editor, Urology News.

I have been a urology registrar for six years now... During these six long years, the specialist training system in Singapore has undergone major changes, from the traditional British-based basic and advanced specialist training programme, to the new residency programme with more resemblance to that in North America. I was the second to last batch of advanced specialist trainees from the old system before its end, and most of my juniors were products of the new system. This puts me in a unique position to witness the pros and cons of the old and new training systems.

Entry into a training programme

One of the major complaints among trainees from the old system was the long queue before being able to apply for a trainee position. This was because of the limited number of training positions assigned to each institution per year. In order to become a certified urologist, one had to apply for a basic specialist training (BST) position in surgery, which was a three-year programme with six-monthly postings in various surgical disciplines. At the end of BST, trainees had to pass the MRCS and the MMed (surgery) examinations. With these

qualifications, they would be eligible to apply for an advanced specialist training (AST) position in urology, which was a four-year programme in an accredited training institution. The bottleneck in this training path was between the BST and AST, as there were far fewer AST than BST positions. Trainees who completed BST would often remain as medical officers, before they were appointed service registrars. A service registrar was essentially a dead end job. No further career advancement was possible until one was successful in getting an AST position, which would then allow sitting of the specialist exit examination at the end.

Taking myself as an example, I passed the MRCS examination and obtained the MMed (surgery) qualification in 2008 and was appointed a urology service registrar in November of the same year. The appointment of a service registrar was a high point in my career, as it would be in the career of any doctor who had the intention to pursue the life of a specialist. It implied a bigger pay cheque, the title of 'Mr Shum' instead of 'Dr Shum', and the opportunity to do 'real' urological operations like transurethral resection of the prostate (TURP) instead of 'pseudo' ones like circumcision and inguinal hernioplasty.

Most importantly, it implied that my department had given the approval-in-principle that I would be the next in line to take up an AST position. There was only one AST position in my institution, and it was filled by another person six months previously. In other words, I had to wait for him to pass his exit examination in 2012 before I could even apply for it. Luckily for me, my institution moved to another region in Singapore in 2010, with a wider catchment area. New consultants joined our department, increasing the number of consultants from two to four. Each of these consultants had his own subspecialty skills, including endourology, laparoscopy, andrology, oncology and reconstructive urology. With the increased patient load and teaching capabilities, the department was accredited as an advanced specialist training centre with three trainee positions in 2011, and I was awarded one of the positions in November 2011.

The wait for the AST position was a long and painful one. Many medical officers and service registrars gave up on queueing, and became general practitioners or locums instead, earning a higher salary with more humane work hours. Those who persisted and kept queueing would (hopefully) be rewarded

with a trainee position. Since there were no strict guidelines on the selection criteria for advanced specialist trainees, the waiting period became an effective way for consultants to confirm that the service registrar was indeed worthy of a training position, with a personality suited to the culture of the department, and without obviously detrimental shortcomings in knowledge and surgical aptitude. On the other hand, the waiting period would allow the service registrar to demonstrate a genuine interest in the specialty by remaining patient in queueing and by a willingness to put in hard work beyond a humanly possible limit. It would also allow the registrar to learn the personal styles and traits of each of the consultants in the department.

In the new residency programme, the queue for a trainee position is much shorter. It is a six-year programme. In the first year, trainees go through 12 months of general surgery rotation. In the second year, they go through customised three-monthly rotations in anaesthesia, emergency medicine, nephrology, paediatric surgery and gynaecology. The third to sixth year are spent in the urology departments of two accredited training institutions. At the end of six years, the trainee will be eligible to sit for the specialist exit examination and become a certified urologist. The new system abolishes the long wait by the service registrars, and the training programme is no longer segmented. There are more training positions available each year, and junior doctors, like house officers (interns) and first year medical officers, are also eligible to apply for the positions. In some specialties, even medical undergraduates can apply for a training position. Because of the shorter time spent in the department before becoming a trainee, there is less opportunity for consultants to 'experience' the trainee. The selection criteria to enter training has become more objective and well-defined, often based on how the candidate handles a case scenario during interview.

While this sounds like a happy situation for many who aspire to become specialists, it has done away with the 'apprenticeship' component associated with specialist training. In my opinion, a surgical trainee following a consultant is no different from an apprentice following a master in any other trade. There is a personal touch to this relationship in addition to imparting skills and knowledge. It may be analogised to a

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master handpicking disciples in Chinese kung-fu novels. The master must see certain aptitudes or virtues before accepting a student into the clan and teaching kung-fu moves. A good master also emphasises righteous character building, takes care of the wellbeing of disciples and provides opportunities for them to excel. A master who teaches kung-fu moves indiscriminately to anyone will likely produce villains. In return, a disciple pays respect to the master, does chores, maintains a positive attitude in learning and gives credit to the master for any success in future. The student will, in turn, become the master, choose more disciples and so maintain the chain, generations after generations.

It is not uncommon for some residents in the new training system to express regrets in their choices of speciality, since these choices are often made soon after graduation without a complete understanding of what a particular speciality entails. It is also more difficult for consultants to choose potential residents, since the selection process is now held very early, with limited contact time and interactions between candidates and the departments. Residents also express uncertainty on their career opportunities after passing their exit examinations because their training is now provided by at least two institutions, thus decreasing the departments' sense of ownership over these residents.

Clinical exposure during training

I have no complaints about the training opportunities I have had during my years as a registrar. There are only two registrars in my department. My daily schedule is either 'Operating

theatre' or 'Specialist outpatient clinic' (except Thursday afternoons when my department's weekly audit meetings are held); when I am in operating theatre, the other registrar will be in clinic, and vice versa. And training became even more intense with the increased patient load after the relocation of my hospital in 2010. In my six years as a registrar, I have carried out more than 600 TURPs as first surgeon; and have been involved in hundreds of various major surgeries. Surgery is essentially a technical exercise, and the best way to excel in it is to keep doing it. There is no better way to gain experience besides repetitively exposing oneself to various operative situations. With a fully packed operating theatre schedule everyday, I could confidently perform a 100-gram TURP and discharge the patient without a catheter the very next day, even before I was officially appointed an AST registrar in 2011.

For several reasons, training opportunities have been even better after my official appointment as an AST registrar. Firstly, a relationship based on trust between my consultants and me has been established after the years of hard work together, so they often allow me to run the operating theatre list semi-independently; secondly, my hospital was given fresh funds to procure some of the latest surgical equipment after relocation in anticipation for the increased patient load; and thirdly, there was the set-up of new subspecialty urology services by the new consultants joining us. Laparoscopic nephrectomy, percutaneous nephrolithotomy (PCNL) and retrograde intrarenal surgery (RIRS) are now routine operations happening every week, with occasional reconstructive and trauma surgery adding variety to my training.

Besides a heavy surgical caseload, the availability of new surgical equipment has enriched my training significantly. I am very fortunate to have fully digitalised endourology and three-dimensional laparoscopy in my routine work, thanks to my head of department who is a strong believer in the power of new technology. The more traditional aspects of urology have not been forgotten though, since one of my consultants is in his late 50s. He would insist that I must perform TURPs peeping through the rod-lenses instead of using the video system, and reminds me of the Whitaker's test every time I arrange for a MAG3 renogram.

The lack of a surgical robot in my

institution has been recognised as a weakness in both patient care and training. At the current moment, our patients who will benefit from robot-assisted procedures are transferred to Tan Tock Seng Hospital, which has excellent robotic capabilities. My consultants can then utilise the surgical robot, ensuring that our patients are not deprived of access to the latest robotic technology. With robot-assisted surgery becoming the mainstream in the management of many urology patients, an exchange programme has been established in which I can spend three months in Tan Tock Seng Hospital before my exit examination to gain exposure to the robot-assisted operations. Definite plans are being made to procure a surgical robot in my institution, so that future trainees can have direct access to robotic surgical training.

While a busy schedule raises the bar for quality training, it does come with sacrifices and I have much less time for my family and friends. With all 'office hours' devoted to clinical work, non-clinical activities, like attending multidisciplinary meetings, writing research papers and teaching medical students, are 'displaced' to after-office hours. Weekends are usually spent writing medical reports, reading *Campbell-Walsh*, preparing for various departmental activities such as public forums and GP symposiums, and many 'important' duties like buying groceries to top up the refreshment cupboard and refrigerator in my department.

The new residency programme has attempted to make training more standardised and well defined. There are now training goals for each resident based on seniority, so that juniors can familiarise themselves with the prepuce and the cystoscope, while seniors spend their surgical time blasting away staghorns and taking out cancerous kidneys. The intention is to minimise disruption to the quality of training by other confounders, such as 'fighting' for cases among trainees and different training styles of individual consultants. This makes the overall training programme look good; at least on paper. However, the extent to which the new residency programme can be implemented to such extreme standardisation is often challenged. Since almost all of the consultants are products of the old training system, it is only natural that they overlook these well-defined training targets and teach the residents as they deem fit. They

are successful specialists in their own fields, and their existence testifies to the success of the old training system. Moreover, trainees and residents are still the main workhorse in the public healthcare sector in Singapore. The high patient loads in all the training institutions may result in conflicts with the new residency programme, when the need for efficient resource utilisation implies that a resident is expected to attend to a case regardless of whether the case is appropriate to his level of training. On the other hand, many residents give too much focus to the stratified training goals in the residency programme. It is not rare to hear new residents saying "Why should I do this?" and "Why is he doing this instead of me?", without realising that the provision of healthcare to the society is as important, if not more so, than their individual training needs.

The concept of 'training hours' has been introduced in the new residency programme, in an attempt to give protected time for the residents to study *Campbell-Walsh*, to read journal articles and to write papers. It is a requirement for each department to submit a summary of 'training hours' for each resident on a monthly basis as proof that ample time has been set aside for this purpose. Once again, there are conflicts between service provision and training needs. It is not difficult to see the peculiarity, when consultants and registrars are struggling to clear 100 cases in the outpatient clinic, and, at the same time, a resident sits in the office flipping the pages of *Campbell-Walsh*. And I decline to comment on the validity of these monthly summaries of 'training hours'.

Career prospects after training

In the old training system, an AST registrar would usually get hints from the head of department and consultants towards the end of training about future likely subspecialisation and niche in the department after the exit examination. While it is never explicitly stated that registrars will get a consultant position in their department, most continue to be employed by their training institutions after training. Anyone who was deemed unsuitable to be part of the department would likely have been denied access to the AST programme, so those who successfully become an AST registrar usually got a job in the end. Whether the career prospects for residents in the new training programme are more favourable

than those from the old system remains unknown, at least until the first batch of urology residents complete their training in two years' time.

Conclusion

Changing from the old BST / AST system to the new residency programme was met with both praise and criticism. By shortening the time from graduation to specialist certification, it provides a more rapid relief to specialist care for the quickly growing population in Singapore. Those who have made early decisions to specialise in urology are rewarded with a shorter training pathway.

Whether the new residency programme will lead to benefit or harm remains unknown at the moment. The quality of the urologists trained by the residency programme will be the benchmark in gauging its success. The overall picture will become clearer in the next few years, when the pioneering batches of residents pass their exit examinations.

As a registrar in his final year of training in the old system, I am now busy preparing for my exit examination and making plans for a subsequent overseas fellowship in robotic surgery. I am very grateful to the four consultants in my department for taking me into their 'clan' and grooming me from a naïve surgical medical officer into the chief resident of the department today.

I would also like to take this opportunity to say 'thank you' to my wife, for her tolerance of the 'forever busy' husband for the last 10 years. And yes my dear, I still remember I promised you a honeymoon trip (if I can find the time for it).



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