Two Sides of Managing Manpower

Text by Dr Chia Lingyi and Dr Tey Min Li

As we begin to get a whiff of fresh air after clawing our way through the past three years of pandemic times, it is inevitable that we wonder: could things have been done differently? Although the number of healthcare workers' lives lost during this pandemic is markedly fewer as compared to when SARS hit Singapore in 2003, any life lost is still a devastating hit to the community.[1] On top of that, mental health and morale have been severely impacted.

While newspapers announced that hospitals were coping well and prepared for surges in COVID-19 cases,[2] we on the ground were told multiple times that manpower was strained due to the diversion of manpower to frontline services. Most people would remember leaves being cancelled, having to do extra shifts, and looking after an increased number of patients. Despite the addition of a third medical school in 2013 and an increase in the local yearly intake of medical students, why does it still feel that there are not enough doctors?

In this article, we examine the issue of manpower constraints and burnout from various viewpoints to facilitate better understanding between parties with the aim of bringing people together to reinvent and explore future possibilities.

Why did we feel so burnt out all the time?

Behind every occupied bed is a healthcare team working tirelessly to support the patient's medical needs. When COVID-19 reached our shores, hospitals coped with the surge in patient load by opening more wards (including virtual ones), setting up corridor beds and outdoor tents, and launching community care facilities (CCF).

The unprecedented strain on resources was reflected in a May 2022 *Today* article written by Dr Desmond Wai who said, "in [his] 20-odd years as a doctor, [he has] never seen hospitals here being so full".[3] He shared how four of the hospitals his team contacted were unable to accommodate a pregnant patient with an acute abdomen as they were all operating at maximum capacity.

Complex and ever-changing workflows compounded confusion. Doctors needed to adapt to multiple patient transfers due to changing isolation statuses. Additional time was required to don personal protective equipment (PPE) and sanitise rooms, complete paperwork, and placate relatives who were frustrated by the visitation restrictions. Managing increased patient anxiety and our own dampened morale whenever a patient suffered poor outcomes due to COVID-19 took a heavy emotional toll. And of course, there were the unavoidable urgent medical leaves resulting in last-minute roster changes (dear roster planners, we salute you).

Increased patient-to-doctor ratios and unpredictable day-to-day variability resulted in longer working hours and a lack of control over personal time. There was no guarantee to how long the pandemic would last and when restrictions on annual leave would be lifted. Stress, burnout and disillusionment were central themes that emerged across various personal blogs, social media accounts and public forums.

Why does a shortage exist?

Burnout from the high caseload and low manpower have likely led to the rise in attrition rates. Dr Janil Puthucheary, Senior Minister of State from the Ministry of Health (MOH), said in a statement that healthcare workers are becoming increasingly overworked and "about 1,500 healthcare workers have resigned in the first half of 2021, compared to 2,000 annually pre-pandemic".[4]

Globally, there is a shortage of healthcare workers, with the World Health Organisation estimating a projected shortfall of 15 million healthcare workers by 2030.[5] It is not surprising that developed nations would dangle attractive privileges to entice healthcare workers to work in their hospitals.

Incentivising foreign doctors to work in Singapore to expand the workforce can be considered. However, how much we can and are willing to offer is difficult to determine. In 2007, Dr Wong Chiang Yin, former SMA President (2006–2009), described concerns raised by various doctors regarding job opportunities in response to MOH's plans to bring in more foreign doctors.[6]

Aside from that, a substantial amount of time is required for the recruitment process. By the time doctors arrive, there may be an oversupply leading to new policies being implemented to differentiate doctors. Dr Wong also recounted how foreign doctors working in Singapore faced the risk of their temporary Singapore Medical Council registration expiring when the requirement of conditional registration

was raised from Graduate Diploma in Family Medicine to Master of Medicine in Family Medicine.

As for local universities, there is a lag time between when manpower projections are made, to when admission numbers are altered, to when these students graduate and become doctors.

For any significant increase in the number of doctors, we must also assess if the current doctors are willing to accept a higher level of competition for Medical Officer Posting Exercise positions, residency, career progression and income level in both the public and private sectors.

In addition to "absolute shortage", "relative shortage" is exaggerated during pandemic times. Diverting medical officers to hospitals with higher COVID-19 load and having surgical departments contribute doctors to emergency departments and CCFs can help to increase manpower where it is needed. However, time is required for specific skill sets to be trained (doing calls for another specialty that one is not used to is a very daunting experience).

How can we do better for the future?

More needs to be done to attract doctors to remain in the healthcare system, especially the medical officers and registrars. This is possibly the segment of the medical community that bears the brunt during surges in patient load in terms of physical hours spent doing patient-facing duties and uncertainty in work schedules (as their official working hours and number of overnight calls are not as protected as the house officers').

Perhaps we also ought to be more open-minded about possibilities – does the burden of data entry necessarily only fall on our junior staff (morning entry notes are becoming exceedingly complicated) and do certain tasks really have to be performed only by particular "clinical grades"?

Opportunities for career advancement must be made concretely available. Although specialist training and consultant positions cannot be offered to everyone, other avenues must be available for doctors to pursue a meaningful career with reasonable pay and working hours. More training funds and opportunities can be offered to junior doctors to upskill further. The development of the hospitalist clinician scheme is one that many will be watching closely and we certainly hope it will live up to its potential.

Dedicated career guidance could also be offered to help junior doctors better match their interests, skills and needs with available jobs and sectors with shortages. Open disclosure of information such as the competition ratios for training positions and position vacancies would help junior doctors plan for how they can find good, meaningful work.

The overnight call system can also welcome refurbishment. Some departments have started trialling the float system. During high patient load, locum doctors were employed to assist with some community hospital calls. These can be some of the solutions to help make it more sustainable for doctors who remain in the system.

Admittedly, retaining doctors in the public healthcare system has always been an issue as the public sector will never be able to match the pay rates of the private sector. The socio-economic challenge faced by doctors of the current generation is multi-directional: the average doctor works five and a half days per week (with the occasional overnight shift). He/she may be the only child (or one of two) supporting two elderly parents who may require assistance with activities of daily living. He/she may also be a parent of young children that he cannot personally look after for the majority of the time due to work commitments. Inevitably, other jobs that offer more flexibility – working from home, being able to take leave on short notice – will start to appear more attractive. As such, junior doctors should not be labelled en masse as the "strawberry generation" and their challenges must be acknowledged.

Passion and the desire to do good may be the reasons that brought people to study medicine, but they cannot be the only factors relied on to retain doctors in the public sector. Meaningful training opportunities, career stability, the chance to make a difference in the lives of our patients regardless of their ability to pay, and the prospect of nurturing the next generation of doctors are all factors that contribute to retention.

Ultimately, it may be the daily acts of kindness and mindfulness that matter the most: buying food for the team too caught up with changes; seniors stepping down and spending extra time to lend overworked juniors a helping hand; or a warm hug for the teary doctor who just had a bad call.

Even though we each are small parts of a large system, it feels good when we reside in a system that affirms this: You are valued. You are important. ◆

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Dr Chia is a resident in the family medicine training programme. Outside of work, she manages the website Before Beyond (https://beforebeyond.pages) which provides grief support and raises awareness about end-of-life challenges. In her free time, she makes art at The Iola Gallery (https://theiolagallery.blogspot.com).

Dr Tey is Dr Chia's classmate and currently a medical officer on Medical Officer Posting Exercise. She hopes to try to do some good with her time in life.