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| <b>Institutional</b><br>Operational factors in healthcare institutions | Manpower, patient load and running at capacity | <p>“It was very, very stressful. When someone was on leave, you’re either pre-call, post-call or on call. So you’re constantly doing calls.” – Participant S10, senior cohort</p> <p>“Interviewer: With that doctor–patient ratio, did you have the bandwidth and the time to treat [your patients] as well as you wanted to?<br/> Respondent: Unfortunately, the answer [...] is no. You’re just busy trying to settle your urgent changes. And like I always have to say, save one sinking <i>sampan</i> (Malay word for rowboat) at a time. It perpetually felt like things were on fire and you just had to put out the fire one at a time.” – Participant M9, middle cohort</p> <p>“When I was studying overseas, in [the] UK, discharge issues [weren’t] that common. I mean, patients wanted to go back home; that was the aim. [Here, a] lot of patients don’t want to go back home, they are either home alone, or they don’t have the support at home [...] The waiting time for like nursing homes, community hospitals is very long [...] which makes it difficult for junior doctors to try and offload the admissions and the patients in the hospital.” – Participant J1, junior cohort</p> <p>“Sometimes I feel like [patients] just need someone to talk to. A lot of them keep coming in for, you know, ‘I have pain in my back, I have pain in my back, I have pain in my back.’ But everyone just says, ‘okay, X-ray’s normal, X-ray’s normal, MRI is normal.’ [...] But there must be a reason why they keep obsessing over it. [...] [In internal medicine,] every complaint has an origin, but [doctors] don’t have enough time to address every single one of them. Because sometimes we have 20 patients [to round]. You can’t spend that much time speaking to them. You know, it’s tough, it’s tough. Another issue is when you also get a text saying, ‘bed occupancy rates is 120%, please discharge patients.’ Which is like, how are you supposed to deal with that?” – Participant J3, junior cohort</p> <p>“I felt like maybe the media or the ministry itself portrayed that it was a COVID-related surge that caused a break in the healthcare system. But I mean, those of us who were in the system before, I think many colleagues could testify that it was already overflowing before. [...] Maybe not, not breaking yet, but there was close to overload before. Not entirely new to COVID [but] COVID probably did push it over the edge at the end.” – Participant J2, junior cohort</p> |
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| <b>Policy</b><br>System-level rules and workflows                      | Unenforced policy                              | <p>“Although &lt;redacted: national employer of junior doctors&gt; now is trying to get doctors to not see new patients after 24 hours, meaning to say we can work for like 30 hours but like the 6 [hours] past 24 hours we shouldn’t be seeing any new patients according to the latest &lt;redacted: employer&gt; guidelines if I’m not wrong. [But] I think due to manpower shortages [...] most of the time, I mean like 90–95% of the time, we still have to run clinics or be in [the operating theatre] post-call [...] If you [were to] try and enforce [24-hour calls instead of 30-hour calls] with a lack of manpower on the ground, then the person that ultimately suffers is the patient. Let’s say I go post-call sharp at 8 am sharp, then there’s not enough MOs to provide coverage. See, then yeah, ultimately [it’s] the patient’s care that will be compromised.” – Participant J5, junior cohort</p> <p>“Every clinic in [my list] right now [...] So, two o’clock is first appointment. 2:05 is the next one. Third appointment’s 2:05. Fourth appointment’s 2:05. Fifth appointment is 2:10. So [multiple] appointments are 2:05 to 2:10. Does that mean each patient gets less than 2 minutes?” – Participant J3, junior cohort</p> <p>“The culture of each hospital, the workload is all very different. And I feel like &lt;redacted: national employer of junior doctors&gt; as an overarching, organisational body, I felt like they were very ill equipped to deal with the differences.” – Participant M9, middle cohort</p> <p>“But I think that there are a lot of so-called cultural things that in the practice of medicine, in the hospitals. So for example, the rounding before your MO, and rounding before your registrar, preparing those team lists, exiting late, making sure you finish all the changes before you go. I think those are cultural things.” – Participant M5, middle cohort</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
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|                                                                        |                                       | <p>"[As a resident, we were supposed to] log in hours, honestly, and of course, unsurprisingly, when I log in my hours, it always exceeded, there was always an alert because I always exceeded. So in the end, what happened was instead of the residency, so instead of coming to find out, you know, why am I reaching my hours all the time, this is a thing that should be looked into, things like that, they basically just told me to lie about my working hours, they told me to not log in more than what would exceed the hours you see. So I told her I was logging in my honest hours, and they just didn't care. They just asked me to not more than x number of, regardless of the true working hours." – Participant M10, middle cohort</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Institutional</b><br>Operational factors in healthcare institutions | Administrative load of junior doctors | <p>"When I was meeting fellow junior doctors from other countries, they were allowed to do much more from what our local doctors are allowed to do. [What Singaporean doctors do instead], a lot of it is administrative work, isn't it? Like ordering medicine, taking history, organising scan, all those things are actually not, not very meaningful, learning wise. You'd be probably better if you spent that time learning how to do procedures under supervision." – Participant M5, middle cohort</p> <p>"Our healthcare system is very reliant on the compliance and the confidence of our medical profession. Yeah. So, for example, if let's say an operating theatre needs to be closed, and there are already patients there: in the UK, what happens is that there's a clerk who will rearrange everything. Slot the patient elsewhere, rearrange the anaesthesia review, financial counselling, and all that. In Singapore, you don't have that. Everything is up to the doctor." – Participant J4, junior cohort</p> <p>"I'm not trying to say we are damn great and do what, but it's like, you go through 5 years or 6 of med school and train, and then you end up filling forms and taking bloods, which can be taught in one day and you can start working you know? Some of my classmates, to earn extra money, they become phlebotomists on the weekend and you actually earn more than an on-call houseman." – Participant S11, senior cohort</p> |
| <b>Policy</b><br>System-level rules and workflows                      | Electronic medical records            | <p>"The huge benefit of the computer system is that it brings information with it, but that is also its downfall, because there's so much information to sift through and to look through that sometimes that can make things even more complicated than it really is.... How did we even come up with 'pre-clerking'? [It's] because we have to go to the computer system to pick up all the information. [...] And because there are so many computer systems nowadays, this like, you have to look through every single one." – Participant J7, junior cohort</p> <p>"Can you see how inefficient it is? And unfortunately, I have to say the poor junior officers have to bear [the brunt of this] inefficiency [...] And who has put this in place? [...] They spend thousands and thousands and thousands, hundred thousands or millions of dollars on all these IT systems which sometimes crash or they're on maintenance. You know, and then who has to scramble? The poor junior doctor [...] But all the IT that I've seen. They don't work in favour of the doctor. [...] In fact, this comment by a medical officer recently, she said, you know, it's faster to handwrite when the system was down [...] This was just recently, I can tell you, a few months ago, because the system was under maintenance. How can you have a system that [is] under maintenance from five o'clock in the morning to one o'clock?" – Participant S7, senior cohort</p>     |
| <b>Society/community</b><br>Scope and nature of medical practice       | Increasing complexity                 | <p>"Globally speaking, we're talking about ageing population, much more elderly, much more complex, both medically [and] socially as well [...] [People have] smaller families, no caregiver, heavily dependent on foreign worker, which may or may not work out. [There are] long queues for nursing homes because there's no caregiver available. [...] Very often, [families are] asking the medical team to play a coordinating role in this and it can be very difficult to tie all these &lt;inaudible&gt; together into one plan." – Participant J6, junior cohort</p> <p>"The treatments are a lot more complex. For example, you only had sulfonylureas, metformin and insulins back then. There's no DPP4, there were no SGLT[-2 inhibitor]s, for example. There's no acarbose even, for diabetes, so the complexity in terms of drug decision making, in terms of the interactions, in terms of the complexity of choosing the right treatment, among the panoply of options, has gone up tremendously." – Participant S9, senior cohort</p>                                                                                                                                                                                                                                                                                                                                                                                                                    |

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|                                                                  |                            | <p>"We are doing a lot more than what we could do [previously]. The scope of medicine has expanded, things that used to be done in certain limited locations are expanded. For example, polyclinics have an ultrasound, where it was used to be only a tertiary hospital thing. We can do a lot more lab tests than what we did [before]..." – Participant M4, middle cohort</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Society/community</b><br>Patients and families                | Expectations and attitudes | <p>"But nowadays, you know, it's, it's never so straightforward. I mean, sometimes, yes, there are still family members who have implicit trust with the healthcare system and don't really question anything. But more [often] what actually happens is that there's a lot more questioning, nitpicking, I guess. Yeah. And, and Dr. Google always wants to have a say in these situations." – Participant J7, junior cohort</p> <p>"The workplace is increasingly hostile in terms of interactions with patients." – Participant S9, senior cohort</p> <p>"In my first week [...] I was told by the patient [that they would] report me to SMC, they were going to stop me, they were going to report me to Zaobao (local Mandarin newspaper). [...] When I was an MO (medical officer), [...] there was this patient's family who was very unreasonable. [...] They somehow got my private phone number, [and were] calling me at weird hours of the day. [...] I think they posed as a doctor and got my phone number. They were just calling me at all times of the day to try and scold me, and they wanted really unreasonable things. Like they wanted the on-call doctor to come and give their patient a foot massage. Like 11 plus, 12 plus at night." – Participant M8, middle cohort</p> <p>"I am a GP now and I do like to engage my patients. [But] some patients actually can be quite combative. They can actually believe the videos or whatever that they see on the internet, which says things like, '10 things your doctor doesn't want you to know', you know, or 'your doctor is actually secretly trying to kill you', you know, that sort of thing." – Participant S11, senior cohort</p>                                                                                                                                                                                                                        |
| <b>Society/community</b><br>Patients and families                | Expectations and attitudes | <p>"Updating families is probably one of the changes that does occupy most of the time. Each phone call depends on how the patient is, how critically ill they are. One phone call can take an average of half an hour. And also some families requested to be updated, like more family members request to be updated for the same patient. So that can take some time." – Participant J1, junior cohort</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Society/community</b><br>Scope and nature of medical practice | Defensive medicine         | <p>"The practice of medicine has become, definitely, more defensive than [when] I first knew it. Everything is like because of medical, legal, [...] you can sue for anything now. Especially, I think it's just something that's imparted in from the (United) States, right. So definitely a lot more defensive than before. Therefore, that's why a lot of ancillary work has been done, like documentation, everybody is like running a lot of other things, tests additional stuff, just to make sure you don't miss out that 1%, that could come back and haunt you." – Participant M3, middle cohort</p> <p>"Sometimes patients suspected doctors are trying to make money and then the doctors are suspecting the patients are trying to sue them. So then it becomes a very unhealthy relationship." – Participant M7, middle cohort</p> <p>"Defensive medicine is not helpful to anyone, not to patients, to society, or public healthcare expenditure. [...] When these [medical lawsuits] become public, whether it's warranted or not, there's always a court of public opinion. So the media tends to publish the names of the doctors, everything, even before a conclusion has been made. And I think that's not good. [...] Yeah, our public healthcare expenditure is exploding." – Participant J4, junior cohort</p> <p>"I [spend] more time documenting, and I have to be a lot more careful when I document. [...] More time spent documenting means less time, for example, physically seeing the patient or compromising on time for the next patient, and things like that, especially in a clinic setting whereby we have to finish seeing the patients by a certain time." – Participant J5, junior cohort</p> <p>"The medical legal climate is very different. And I don't mind saying it's mainly because of the medical legal climate that I've decided to stop working." – Participant S7, senior cohort</p> |

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| <b>Interpersonal</b><br>Impact of relationships on self                         | Workplace bullying                | <p>“We just get totally trashed by our registrar in particular... they were extremely, extremely, unreasonably demanding. [...] The registrar would expect, like absolute perfection for everything, even for things that shouldn’t matter. So for example, for the team list, that we print out for the team every morning, I remember once that she actually completely ripped the HO’s (house officer’s) apart, just because the lines—the columns that are outlining the boxes of the details on the team list—just because the lines were of different thickness. [...] Then the other things that they will pick on are like your seniors’ coffee orders, you know, the <i>kopi o kosong</i> (Singaporean term for black coffee) and everything for each person, every single coffee order, their breakfast order had to be, you know, perfectly done and listed. [...] The attacks became very personal... to a point where it’s not unusual to have vulgarities thrown at us. We not only [had] vulgarities thrown at us, but physical objects—we have the patient folders being thrown at us directly. And in the operating theatre, you have scalpels being thrown at you.”</p> <p>(In a later part of the same interview) “So [a mentor from a different department] actually tried to help me ask for help from my team senior but in the end what I got was more backlash, so I got bullied even more and got more crap thrown my way, and things got worse and eventually I couldn’t take it [...] I really couldn’t take it and at one of the exit rounds, I just went off to toilet and then I stole, before I went to the toilet I stole &lt;redacted: medication&gt; from drug stores and I tried to inject myself.” – Participant M10, middle cohort</p> <p>“[Redacted: department], I shall not name which hospital, wasn’t as friendly. Every day, every day I feel like we are taking an exam every day, we are afraid that the consultants would throw files at us and make us cry.” – Participant M4, middle cohort</p> <p>“But last time, generally there’s a lot of blaming culture on the junior doctors, because the seniors they always get away with their own—the consultants, not the reg—they get away of things, then they also don’t like to blame each other during the M&amp;M (morbidity and mortality discussion), so every time it’s the fault, the slip-up will chunk all the MOs (medical officers) or sometimes the reg (registrar).” – Participant S11, senior cohort</p> |
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| <b>Individual</b><br>Policy relating to actual or anticipated career trajectory | Feeling trapped, sour or stagnant | <p>“I thought that was the strength of the MOPEX (Medical Officer Posting Exercise) system in that every 6 months you can choose something else. So you can try you know radiology, psychiatry, anything that you choose. But it didn’t really work out in that sense, because a lot of the times you actually don’t really get what you chose.” – Participant J2, junior cohort</p> <p>“A lot of us feel that it’s very, that we feel that the bond is just to trap us in our system, for very practical reasons. Because they don’t want us to just get our full registration and leave and go [to the] private [sector], you see, they know that we will do that. [...] And it’s not, it doesn’t make sense that you know, that our local medical school fees are actually that expensive and governments are subsidising you. That was what we were told.” – Participant M10, middle cohort</p> <p>“It produces a lot of doctors that are quite sour. [...] The moment their bond ends, they leave.” – Participant S11, senior cohort</p> <p>“My year was the first year with a proper bond. [...] Some people felt there was like ‘slavery’ and so on. Because you know, not much, not that much pay compared to what you earn outside. And, of course, long hours and not being able to get or choose the postings that you want, and so on, so forth. So of course, it’s something that cuts both ways, your employment is guaranteed, but you have very little control over it.” – Participant S2, senior cohort</p> <p>“I think there are more options in terms of specialisation, but there’s also much more competition.... Because in old days, we wouldn’t write papers or participate in this kind of research, unless you are either a very senior MO trainee, or you’re a registrar.” – Participant S6, senior cohort</p> <p>“I was posted to &lt;redacted: department&gt; 3 times against my will.” – Participant M8, middle cohort</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
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| <b>Individual</b><br>Policy relating to actual or anticipated career trajectory | Concerns about remuneration                  | <p>“There were postings where I worked consecutively for 3 to 4 weekends, so that means like, I think the record was 27 days consecutively. Yeah so when you factor all those things together, then you realise, hey, you know, perhaps we should be a bit more fairly remunerated for our time. – Participant J4, junior cohort</p>                                                                          |
|                                                                                 |                                              | <p>“You can’t even, you know, speak about stuff, if you’ve got a ridiculous mortgage. When I try to inspire younger people to say, “oh, do a bit of academic work, do teaching, do research...”, [They’d say], ‘sorry, I don’t have time or you know, I have to go private practice because my wife doesn’t work with 3 children.’ That’s astounding. That’s outrageous.” – Participant S5, senior cohort</p> |
|                                                                                 |                                              | <p>“It’s only when I started working then I realised for the amount of salary I’m getting and the pay, it’s really a pretty bad deal...and also [when] you compare to what your friends who are non-medical are making then the [disgruntlement] kind of comes in.” – Participant M9, middle cohort</p>                                                                                                       |
| <b>Individual</b><br>Impression of work as a junior doctor                      | International medical graduates’ experiences | <p>“It took a lot to adjust to [the] Singapore hospital system. I mean, just I mean, just the fact that, you know, the computer system is totally new. And, you know, acronyms. Yeah, the way things are done, and [even] the patient demographic is so different. Right, right. And, yeah, I guess [the] culture as well.” – Participant J7, junior cohort</p>                                               |
|                                                                                 |                                              | <p>“The patients are a lot sicker. There’s a lot more patients [...] [My experience overseas] was a breeze compared to what we’re doing here...” Participant M8, middle cohort</p>                                                                                                                                                                                                                            |