Longitudinal Primary Care: KEEPING THE FIRE BURNING

Text by Dr Wong Tien Hua

A review of burnout in primary care physicians by Dr Lawrence Ng was published in the *Singapore Family Physician* (SFP) in 2016.[1] It quoted Maslach's description of burnout as "... **an erosion of engagement** with the job. What started out as important, meaningful, and challenging work becomes unpleasant, unfulfilling, and meaningless. Energy turns into exhaustion, involvement turns into cynicism, and efficacy turns into ineffectiveness."

A burned out physician feels depleted of energy, unable to connect to or care about his/her patients, and becomes incompetent and unproductive at work. The doctor-patient relationship suffers along with effective care delivery.

Medicine is an uncertain art and this is especially poignant in the primary care setting where patients present with undifferentiated illnesses. Dealing with **uncertainty** is a clinical skill that has to be mastered, but it is counter-intuitive to junior doctors who are trained in the hospital setting where the latest diagnostic facilities are available and where diseases have evolved and become more apparent. This transition from specialist-based training to the community setting, where one has to rely on clinical acumen amid limited resources, is a stressful endeavour.

Society has also always placed high expectations on doctors, with patients now more knowledgeable and connected than ever before. Patients are more demanding and intolerant of uncertainty, because they are used to the fact that they are in control of many aspects of their lives. However, even with the power of the Internet, which provides information at the touch of a button, patients who are not medically trained may find such open access to information to be overpowering and confusing. Their sense of self-control may be threatened, leading to anxiety and frustration which they pass on to the physician. As addressed in the paper, difficult patient encounters are a major predisposing factor to physician burnout.

The demands of family practice in Singapore means that the physicians need to spend long hours in the clinic to ensure accessibility. Most often, the evening and weekend sessions are the busiest times for family physicians whose practices are located in residential neighbourhoods, resulting in less time spent with one's own family and on leisure activities. The ethos of a "good" doctor is to place the needs of patients above self, and this renders the doctor prone to spending excessive time at work to the detriment of family.

Setting up a family practice in the community is indeed a daunting task for doctors who wish to take the plunge into the private sector. One starts off with the task of selecting the right location with the right overheads, then applying for the clinic licence, stocking up and hiring of staff. Once the clinic opens, one has to worry about maintaining the business and ensuring a good level of service so that patients would want to make a return visit and recommend it to others. Needless to say, there are a lot of responsibilities and worries that a family practitioner has to bear. If this is coupled with the long hours spent confined within the four walls of the consultation room seeing repetitive cases, then the work may become mundane and even meaningless, leading to physical and mental exhaustion.

There are many interventions available to tackle burnout, including self-care techniques described in the aforementioned issue of the SFP.

Staying engaged

If Maslach describes burnout as an erosion of engagement, then the ability to stay engaged in one's practice is critical especially over the span of a doctor's career. I believe that the key to combating the feelings of detachment and depersonalisation that occur in burnout is to focus on nurturing a strong doctor-patient relationship, especially among primary care physicians.

The well-known Stott and Davis model for primary care consultation describes four essential tasks for the doctor at each encounter.[2]

- Looking after the acute problem
- Managing any concomitant chronic problem
- Modifying health seeking behaviour
- Opportunistic health promotion

The model recognises that each patient encounter is not just about the acute problem at hand or about managing the patient's chronic illness, but that each encounter actually carries far more potential with unique opportunities to

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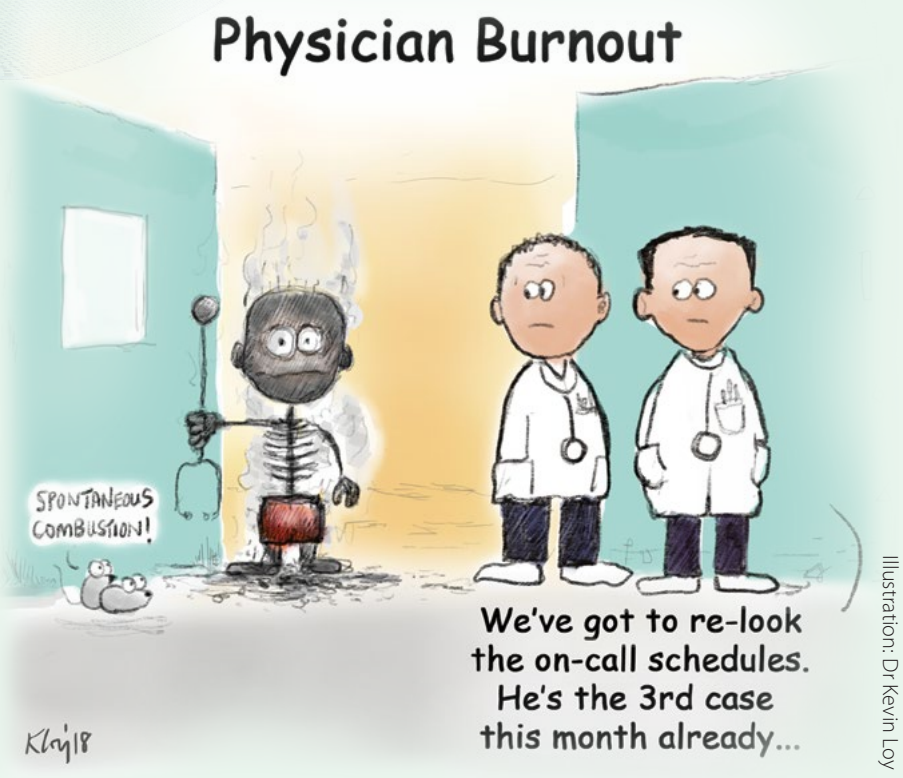

Illustration: Dr Kevin Loy

engage the patient in behavioural change, and to "nudge" the patient towards a better quality of life.

For this to happen, two conditions must be present:

1. The doctor and the patient must be committed to a therapeutic relationship of trust; and
2. The relationship must take place over an extended period of time.

This means that the element of time played out over months and years is a necessary component of effective care delivery for family physicians.

Each encounter is no longer an isolated event beginning with the patient entering the consultation room and ending with the patient leaving the clinic. Instead, the patient encounter can be seen as part of an ongoing conversation that is picked up where the previous one had ended. The interval between each encounter can be months or even years, but each individual consultation is part of a continuum and a touch point that makes up the dots that form a continuous line – the longitudinal line of care. The doctor is aided by having a comprehensive medical record of each consultation, including the conversations that occur, building on the previous knowledge base with new insights and information about the patient.

A change in attitude

A doctor's approach to his/her patients will change once he/she adopts an attitude of long-term holistic care, with the realisation that he/she is going to bear the responsibility for his/her patients over decades. What is not addressed today may come around and strike years later. For example, if a smoking habit is not addressed, both the patient and the doctor may need to deal with the consequences of lung cancer in the future.

I do not think that this attitude can be instilled or that it is a skill that can be trained; instead, it is a perspective that the doctor comes to appreciate over time. The uniqueness of practising family medicine in the community is that *as the practice matures, so too does the doctor-patient relationship.* The relationship strengthens as the doctor learns more about the patient and eventually the patient's entire family, a nd is able to appreciate the context behind each and every encounter.

An established clinic also tends to have a loyal pool of patients who are more open to behavioural change. The initial few visits are usually business-like as patients seek consultation for biomedical problems, but at the same time, these patients also subconsciously observe the doctor to see if they are comfortable enough to share their intimate medical information. Patients who do not "click" with their GPs will eventually move on to other practices and in this way, an established practice self-selects its patients over time.

It is with this insight of longitudinal care that the practice of family medicine is so engaging and interesting, because even though patients may seem to present with similar and repetitive medical conditions, each encounter is actually quite unique. Ultimately, the experienced family physician makes use of valuable contact time to steer patients towards better health. ◆

References

1. Ng CLL. Burnout in primary care physicians and interventions – an evidence-based review. Singapore Fam Physician 2016; 42(1):6-12.

2. Stott NCH, Davis RH. The exceptional potential in each primary care consultation. J R Coll Gen Pract 1979; 29(201):201-5.