Reflections on GENERAL PRACTICE in the UK

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I was known as the "Singaporean who returned home after a 23-year hiatus abroad" and this was always my springboard to initiating conversations with new colleagues in my first post back here in 2015.

Yes, I did return due to family reasons – mainly for my ageing parents and for my two sons to receive their education here.

In Daventry, England, I was a full-time GP partner in a seven-partner practice that cared for 13,000 patients empanelled to the practice (unless they relocated out of our clinic's catchment area). This continuity afforded me the opportunity of dealing with a spectrum of illnesses across all ages, as well as getting to know my patients personally.

The UK experience

GPs in the UK are independent contractors of the National Health Service (NHS), with healthcare fully funded at the point of entry into the NHS. Our goals sound simple – prevent the healthy from falling sick, manage the chronically ill in the community, reduce hospital admissions and allow our patients to die in their own homes. This is achieved through the complex web of clinic- and community-based staff, with care coordination organised by their attending GPs. I therefore donned various hats at work – friend, advocate, social worker, care coordinator, counsellor, liaison and link to secondary care – in addition to being a business partner and ensuring a sustainable and relatively profitable business. I had to know the more than 1,900 patients on my list very well, eventually grasping (some more relevant than others) the complex interplay of how their psyche, social circumstances and relationship issues (at home and work) affected their well-being.

GPs also commission health services within their locality, including within the hospitals. Thus, the "gatekeeping" role, in regulating the flow of patients in and out of hospital, was an essential one. Care and communication were further augmented by an excellent IT platform (SystmOne) linked to the national patient electronic records. SystmOne was also linked to the local pathology department, allowing for results to be received daily, together with external correspondences and outpatient or discharge letters. It also traversed out-of-hours care when all clinics would close for on-call GPs to take over (GPs generally work from 8 am to 6.30 pm on weekdays), allowing for the tagging of essential information such as "Morphine dependency" onto patient records, updated information for palliative patients, or other practical things like door codes for home visits.

The ten-minute appointment system allowed for more control in my working day, facilitating anticipatory care, as I knew in advance who was coming to see me. Our morning clinics lasted

about 3.5 hours and the afternoon ones, 2.5 hours. In between, we would consult via telephone appointments and conduct home visits. To avoid burnout, one session a week was dedicated to developing a special interest. Mine was in GP education (I trained GP registrars in a deanery), GP appraisals and musculoskeletal medicine. My other colleagues were GPwSIs ("GPs with Special Interests", affectionately called "gypsies") in areas such as cardiology and genitourinary medicine, and one even performed non-scalpel vasectomies at our practice!

The appointment system meant that patients generally had to wait 24 to 48 hours to be seen (unless their symptoms were deemed urgent and they were given a "same-day appointment"), thus providing them with the opportunity to reflect on the reasons for the consultation. Patients generally had no issues vocalising their concerns and expectations, and my role was to share management options and arrive at a mutually agreed management plan. I was always touched by the many patients who made the effort to dress up for their appointments – men in suspenders and tweed coat jackets, and ladies in their dresses. The personal level of care afforded benefitted both parties, facilitating management on an even more individual basis, taking into account patients' individual backgrounds and their support mechanisms at home, at work and within the community. For those with more chronic and complex conditions, a team-based approach (ranging from community nurses providing home nursing to a home IV antibiotics service and social workers) is used in an open manner, encouraging ownership and contributions from all team members. We also managed a community hospital, which allowed us to admit subacute cases directly from home for medical management or titration of therapeutic/palliative medications rather than admitting patients into the hospital. We also had beds for step-down care and regular consultant support.

Back in Singapore

Fast forward now to Singapore where I try to provide this same style of care in my neighbourhood clinic, which serves a predominantly elderly population. I took over from an extremely dedicated GP who had run this clinic for 38 years. I have realised that patients everywhere are more or less the same; they experience the same anxieties and appreciate doctors who consult well. I do experience more consumerism in the sense of higher patient expectations, due to the perception that they are paying for my service. I also have had to devote a considerable amount of time to handling the various interesting health beliefs (cultural ones are the most challenging!), such as they are down with the flu because they were caught in the rain or that an injection is the most effective means of treating all illnesses.

My current population of patients is also less vocal and not used to the sharing of options when discussing management. Most of them prefer to be told what to do rather than to learn more about their conditions so that they can actively manage them. In my aim to be more patient-centred, I have been trying to focus more on encouraging their contributions during the consultation.

I quietly look forward to the day where GPs have access to a more savvy IT system that would allow a quicker and more efficient flow of patient information, although I have to say that GP Connect does a real good job compared to most other systems that I have encountered in the UK.

In the meantime, I remain committed to passionately providing my own style of primary care to my patients until "Crumbilitis Crumbilosa" [a] eventually catches up with me! ◆

Note

a. "Crumbilitis Crumbilosa" is an affectionate term I use with my patients in the UK to imply "getting old to the point that my bones are starting to crumble and fall apart!"

Legend

1. Feeling back at home again... in Clementi

Dr Seow completed his general practice training in Oxford in 2001 before working as a full-time GP partner for 11 years in a group practice in Daventry, England. He returned to Singapore in 2015 and now provides primary care services to the local community that he serves in Clementi.