GENERAL PRACTICE RESILIENCE: SOLO IS NOT SILO

Text by Dr Wong Tien Hua

Deciding to go into general practice has never been an easy choice. In earlier days, general practice was sometimes a default vocation that doctors slipped into when they could not specialise. Family medicine was not well defined and the skill sets and competencies required were not adequately covered in medical school.

GPs were true generalists who had to learn how to handle whatever cases that came their way. They had to develop the clinical skills and acumen to treat patients spanning the demographics of age, illness and social status – including patients from the very young to the very old, patients presenting with both physical and mental ailments, as well as patients suffering from both acute and chronic diseases.

The GP also has to contend with the business and management aspects of running his/her clinic. Most GP clinics are run by solo practitioners who own their practice, typically operating with long opening hours. They have to hire and train their clinic assistants, manage the logistics of a pharmacy, and attend to accounts and legal matters. There is also the additional burden of handyman tasks such as electrical work and plumbing, and nowadays with the increasing use of computers, having to troubleshoot information technology (IT) matters as well. It is like having the roles of the chief executive officer, clinical services, human resources, legal, accounts, property management and IT departments all rolled into one.

All the extra tasks may sound daunting and will certainly take time to master, but I suspect most GPs will not trade that away for the professional autonomy that they currently enjoy, and the ability to practise medicine in a setting where they can make a difference to the community. Running one's own practice allows the doctor absolute freedom to do whatever he/she chooses within legal and ethical boundaries. "Being your own boss" means that there is no one to report to and that you are able to be the captain of your own ship.

The *Straits Times* recently ran a feature on Dr George Khoo,[1] possibly Singapore's oldest practising GP at the age of 89, who has been practising at his solo clinic at Rochor Centre since 1963. In the article, he described his experience treating patients from the nearby brothels and opium dens back in the days. He has even treated not just three, but four generations of family members. One can imagine the immeasurable long-term impact Dr Khoo has made to the health of the community in Rochor, where his practice has been embedded in for more than 50 years!

Roles of the family practitioner

The concept and practice of family medicine, and the operations of general practice that we see in Singapore today, have indeed come a long way.

The clinical skills required to perform in a primary care setting is now well documented. The World Organization of Family Doctors (WONCA) published a good description of the special characteristics and roles of general practice and family medicine (see page 10). It includes not only factors of good clinical care but also takes into account the social, psychological and even philosophical aspects of holistic care.

The training of family medicine starts from medical school with the necessary curriculum in family medicine, as well as exposure and attachment to primary care services. After graduation, residency for family medicine is available to train doctors towards the Master of Medicine (Family Medicine) degree. Doctors can also opt to sign up for the two-year Graduate Diploma in Family Medicine course conducted by the College of Family Physicians Singapore. The Register of Family Physicians was set up in July 2011 and serves to recognise medical practitioners who have relevant qualifications and set the standards of practice for family medicine.

Solo but not silo

Many commentators have long hailed the demise of the solo practitioner, given the rapid changes in Singapore's healthcare landscape. The fact is that the majority of private GP clinics are still operated by solo GPs today, the percentage of GPs in group practices has not increased in the past decade. The Ministry of Health's Primary Care Survey 2014 showed that only 27% of GP clinics considered themselves in a group practice (two or more clinics).[2] The figure was 27% and 26% in 2010 and 2005 editions of the survey, respectively. The difference is in the groups; the number of clinics in group practices has grown, with a significant increase in group practices that have 40 to 59 branches.

Because medicine is becoming more complex, no single doctor can effectively manage the wide range of cases that present in primary care. Hence, there is now a bigger focus on a team-based approach.

Government polyclinics are excellent examples of multi-disciplinary primary care setups, providing high-quality care and services all under one roof. The latest new generation polyclinics look like private establishments, with modern furnishings and the latest technology such as self-registration, electronic records and remote medication collection.

Family Medicine Clinics (FMCs) were introduced in 2011 as a response to the shifting need for team-based approaches in primary care. FMCs are managed by a group of like-minded GPs who work together to provide comprehensive team-based care for patients, especially those with chronic diseases.

The **business environment** has also been getting harsher and more unforgiving. Gone are the days of cheap rental, low wages and low cost supplies. Operating costs for clinics have been on the rise, with rental and staff salaries now accounting for a large percentage of expense. The cost of drugs and equipment has seen year-on-year increases; yet professional fees have not changed much over the past decade. Because of smaller volume, solo GPs find it hard to take advantage of economies of scale; they therefore need to constantly operate under maximum efficiency in order to survive.

Regardless of these external pressures, I still believe that there is a unique role for solo GPs despite the rapid changes in our healthcare system, and I also believe that solo GPs are more resilient than most would estimate. Because the fundamental unit of healthcare boils down to the doctor-patient relationship, the solo GP who provides personalised healthcare and who is accessible to the community will continue to be sought after by patients and families. Patients seek that *one* family doctor whom they can relate to personally. If you look at the roles and competencies of the GP as described by WONCA, there is nothing listed that a solo GP cannot do, and nothing that cannot be overcome with some support and technology.

The singleton GP today may be *solo in makeup, but no longer silo in function*.

Advances in technology mean that doctors can be well connected. For example, doctors can join in a physician network to consult with other colleagues, use electronic records to access investigation results and

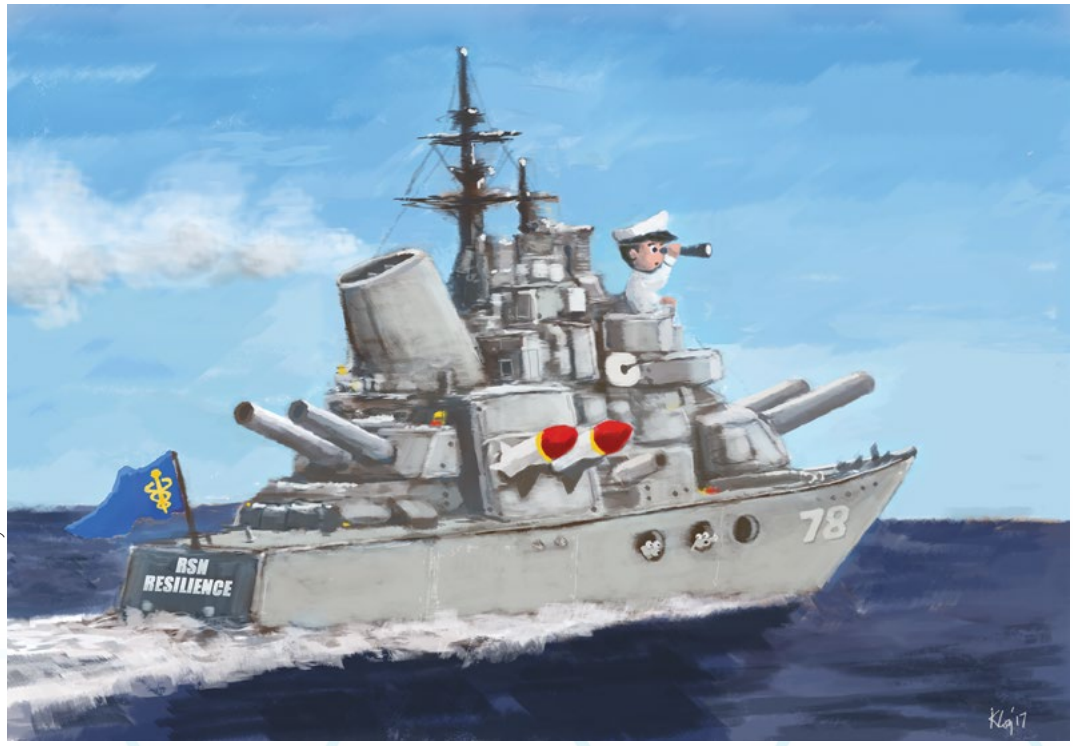

Illustration: Dr Kevin Loy

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procedures done, and enlist and refer patients to allied healthcare workers that are available in the community. The advent of the smartphone and mobile apps has allowed doctors to join virtual chat rooms where clinical conundrums are discussed. The National Electronic Health Record is being refined and will eventually be widely available to primary care physicians, allowing them to tap into the public hospital database.

Technology also enables solo GPs to purchase drugs and equipment through cooperatives and online markets where collective bulk purchase can achieve lower costs. SMA just launched our **SMA eMarket** at the recent FutureMed 2017 event.

The SMA eMarket seeks to become a common procurement platform for private medical clinics and healthcare institutions to access basic medical supplies, equipment and services.

The Ministry of Health announced the scaling up of **Primary Care Networks** (PCN) at the Committee of Supply Debate 2017. The PCN pilot had shown that private GPs could operate very effectively with good outcomes as long as there was adequate support that enabled them to handle complex diseases. In PCN, solo GPs and small group practices will be organised into virtual networks to deliver care through a multi-disciplinary team approach. Counsellors and diabetic screening services will be provided on-site at the GP clinics to assist in managing chronic diseases.

The European definition of General Practice/Family Medicine[3]

The role of the GP includes:

- being the point of first medical contact within the healthcare system, providing open and unlimited access, for all health problems both acute and chronic;
- coordinating care within the healthcare system;
- practising patient-centredness in the context of family and community;
- enabling patient empowerment;
- focusing on a long-term doctor-patient relationship and continuity of care;
- making clinical decisions taking into consideration the prevalence of illness in the community;
- managing undifferentiated illnesses at presentation;
- ensuring health promotion and community health; and
- dealing with all aspects of health in their physical, psychological, social, cultural, and even existential dimensions.

WONCA also defined six core competencies that are essential for the GP.

These include:

1. Primary care management such as dealing with undifferentiated illness.
2. Person-centred care including respecting patient autonomy.
3. Specific problem-solving skills to guide decision-making in primary care settings where sophisticated tools are not available.
4. Comprehensive approach to care including acute and chronic problems, health promotion and preventive health.
5. Community orientation emphasising on what the patient presents in the context of family and social settings.
6. Holistic approach.

Antifragility in general practice

The concept of antifragility was proposed by Nassim Nicholas Taleb in his 2012 book, *Antifragile: Things That Gain From Disorder*. **Fragile** systems break down under stress and tension while **resilience** allows systems to resist shocks and to recover from failure. However, the opposite of fragility is not resilience, because resilience maintains or returns the system to the same/prior state. Taleb coined the word "antifragility" to describe a system that goes beyond resilience or robustness. Antifragile systems not only recover but *improve* under stress. An example in biology is the necessity of constant exercise and bearing of weights to stress and hence strengthen bones and muscles; the removal of which results in atrophy.

Based on the above description, **I think that general practice is antifragile**. In the face of rapid change and constant challenges, general practice remains not only resilient but adaptive as well. New policies and schemes have come and gone. GPs have seen through different partnerships, engagements, funding plans and business practices, and have continued to adapt, consolidate and thrive amid all these.

Finally, to the solo GPs who sometimes feel that their existence is being threatened, I quote the German philosopher and existentialist Friedrich Nietzsche who so eloquently said: "That which does not kill us, makes us stronger." ◆

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