Working as a GP: Applying the Core Values

By Dr Wong Tien Hua

Being a General Practitioner was not as easy as I had thought.

As soon as I started life as a GP, I noticed a mismatch between what I was taught in medical school and the actual experience on the ground. The concept of disease was to tackle what made the patient ill, that is, the pathology of the disease; but in the GP setting, one had to go beyond that to tackle the sickness, that outward expression of the disease. This varied with each patient depending on his background, culture and environment. In addition to diagnosis and treatment, I found myself not only having to address the patient's fears, but that of his spouse and family members, and how the dynamics of his work and family will ultimately influence the outcome of the illness/ sickness.

I think GPs are ideally suited to understand this because of the extended timeframe we have in our contact with the patient, beyond the immediate care of the presenting problem. Continuity is our trump card. This is where the concept of holistic care and healing comes in, because many times, the cure is not straightforward, and sometimes not even possible. Referral to our specialist colleagues helps to solve specific problems, but the patient will eventually return and his overall health and well-being again falls squarely on our shoulders.

So what are the core values of a GP? Is there anything to define it as a unique discipline? Stephens G G described General Practice as a counterculture[1] against the movement of fragmentation and impersonal care brought about by sub-specialisation and use of technology. In A/Prof Goh Lee Gan's Sreenivasan Oration in 2001[2], he listed six central values of this GP counterculture. It is worthwhile to explore how we can apply them to daily practice.

KNOWING YOUR PATIENT

Patient-centred care and attention to the doctor-patient relationship is the essential ingredient in a successful GP practice. Whereas specialists define themselves in terms of content (diseases, organ systems, technologies), GPs form relationships prior to the content. This certainly is the core value and our "secret sauce" – something that needs to be on the slow cooker, nurtured over many years and numerous encounters. Patient-centredness involves finding out the patient's views to understand the illness from his perspective. Proven benefits include relief of patient anxieties, improved satisfaction and enablement. When the doctor is familiar with the patient's history, background and problems, the consultation somehow seems more satisfying. Patients therefore tend to look around for a GP that they are comfortable with and once they have done so, would usually prefer to stick with their regular family doctor.

In a recent study[3] to elicit patients' concerns, outcome measures included a patient satisfaction questionnaire. In addition to asking whether the doctor was careful in history-taking and examination, opinions were sought for the following statements:

- I thought this doctor took notice of me as a person.
- The doctor was interested in me as a person.
- I understood my illness much better after seeing this doctor.

It would be useful to ask ourselves whether our own patients think of us this way.

Holistic approach to the patient and his problems recognises that the patient is more than a sum of his parts, that is, not to view patients in the narrow context of their diseases but within the framework of the total environment. We should not limit ourselves to the alleviation of symptoms or cure of diseases, but focus on health preservation. Disease prevention is one area that we should pay more attention to.

PREVENTING DISEASE

Emphasise on **preventive medicine** because this has greater long-term impact on health status than curative medicine. Every patient visit presents an opportunity to apply some kind of health prevention or education, time being the only limiting factor. In 1979, Stott and Davis presented an influential model that elicited four potentials of the encounter between patient and doctor: management of presenting problems, modification of help-seeking behaviour, management of continuing problems, and opportunistic health promotion. Opportunistic preventive medicine is therefore considered to be part of good medical practice.

There are some arguments that doctors should just focus on each patient's reason for encounter, instead of being distracted by delving into preventive measures with questionable relevance and outcomes[4]. This is especially true in the local context where time is a commodity doctors can ill

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afford. The range of screening methods has also increased in recent years, and normal people are more and more likely to be labelled by some criteria as "at risk". Screening packages offering blanket tests are the norm and mobile screening centres ply the streets offering free cholesterol and blood glucose tests. This is where the GP, as a clinical generalist, will need to maintain a broad view of his patient's personal health needs and be responsible for their long-term avoidance of chronic diseases. As a patient advocate, GPs need to deal with all the information and work with patients to decide which tests and preventive measures are the most appropriate.

DEALING WITH UNCERTAINTY

The next three are not really values by definition, but factors uniquely seen in the GP setting which define the family doctor's work.

The ability to **deal with initially uncertain symptoms** is important. I would hazard that a significant number of cases we see in General Practice are non-specific with no defined treatment or cure (thankfully they also happen to be self-limiting). A solo GP has few colleagues to turn to, and certainly none immediately available to confirm the problem. The experienced GP must continually be able to assess and criticise his own levels of uncertainty. If one refers too often, the GP may not actually be making responsible decisions in the patient's best interest. The confidence of the patient may be eroded – they may think that the GP has no ability to handle the problem. Conversely, a high tolerance resulting in too little referrals may be dangerous. Self-awareness of one's limitations is crucial, and the GP must always keep in contact with other GP colleagues, specialists, and stay relevant through CME activities.

Stephens argued that "patient management is the quintessential skill of clinical practice and is the area of knowledge unique to family physicians". To deal with uncertainty, building a sound doctor-patient relationship is the cornerstone of reassurance and an effective consultation. This is why patients see a doctor, instead of self-treatment, because they are worried of serious problems.

MANAGING DIVERSITY

The family doctor looks after people **across the whole spectrum** of age groups – he is a specialist in breadth, unlike the hospital specialist who is a specialist in depth. Being able to confront large numbers of unselected patients with unselected conditions require a kind of special skill, one which is more often learnt than taught. In his innovative book *The Inner Consultation*[5], Roger Neighbour described five "check points" in a consultation process, the last being housekeeping, or looking after yourself. Seeing patients one after the other will have a heavy toll on the doctor's performance and this may be unfair for subsequent patients. The doctor must "reset" and quickly set aside all traces of the previous consult to prepare for the next case, which is usually totally different and require different skills to manage.

The family doctor is willing to look after the patient not only in the consulting room but also in the **home and other settings**. This is the basis of house calls, hotel calls, school visits, elderly home visits, factory clinics, and attending to patients on board ships, trains and aeroplanes. A GP cannot think of physical boundaries in the course of his work. Information can be obtained from one visit that no amount of history-taking could. Whilst I was working in Hong Kong I had the opportunity to cover an outlying island community that had no access to hospitals. An expatriate couple had recently adopted a Chinese child who developed an episode of asthma at three in the morning. As we sat down for a cup of tea in her kitchen waiting for the portable nebuliser to take effect, the mother described how exasperated and worried she was as she had seemingly done all she could to bring her child for treatment. I looked around her kitchen and commented that perhaps she should stop keeping her two cats in the house. In the local setting, our uniformed blocks of HDB flats contain a whole range of living environments nestled side by side. Well-to-do families are situated upstairs to extended families living in more crowded conditions. Knowledge of the patient's home environment is part of holistic care. It is this aspect of community involvement that makes GP work always interesting and challenging.

PRACTISING DIFFERENTLY

GPs have long been called the "cough and cold" doctors, and I do not deny that this represents the primary reason for attendance in a fair amount of cases. However, in light of the above, perhaps we can see things a bit differently even for simple problems like patients with cough and cold:

- Patients with cough and cold have different belief systems, and may be worried of serious problems. Have you addressed them?
- Each patient with cough and cold will present and respond differently depending on his background.
- Patients attending with cough and cold present an excellent opportunity for health screening and preventive medicine.
- Make sure that the patient does not have any serious problems, and reassure him if none is found.
- A three-month-old baby with cough and cold is different from a 90-year-old woman with cough and cold.
- Who is going to look after this patient at home? Is he likely to spread it to other family members? ■

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