

# Engaging the Private Practitioners

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*"Isn't that an iceberg on the horizon, Captain?"*

*"Yes, Madam"*

*"What if we get in a collision with it?"*

*"The iceberg, Madam, will move right along as though nothing had happened."*

-'The People, Yes'  
Carl Sandburg

Time compression has a curious way of giving new meanings and insights to past events. For example, over the last year or so, three events in the general practitioner (GP) scene in Singapore would have stood out as significant when re-examined collectively in compressed time. There is a certain cautious exhilaration or relief about this sequence of events, not unlike the feeling that one gets when he or she is at the verge of or has just released a taut coil spring.

The first was when the Severe Acute Respiratory Syndrome (SARS) hit Singapore in 2003. The private GP fraternity, which was so frequently labelled as "diverse and fragmented", became united in a formidable defence against SARS. Even more significantly, this was done through efforts and initiatives emanating from within the fraternity itself. One senior family physician had described the private practitioners as the often forgotten 'third force in primary care' (the other two being the polyclinic clusters) - it was the 'silent' majority revealing rare glimpses of its awe-some potential. This is the coil spring.

The second event was the Glasgow study trip by the primary care physicians to explore ways to improve the quality of primary care in Singapore. It was a rare occasion when the public and private sectors were able to share and exchange diverse perspectives on health care delivery. The observations and reflections from the study transpired into the seminar on Transforming Primary Health Care – The Scottish Experience on 15 May 2004. This is the tightening of the spring.

The third event was the recent Academic Year Commencement Ceremony on 26

June 2004. During that meeting, the President of the College officially announced plans on vocational training that may eventually alter the landscape of family practice in Singapore. This is the point at which the spring gets released. It is common experience that for that fraction of a moment when the taut spring is about to be released, one might stare at the spring in anticipation, and yet be apprehensively ready to close one's eyes. Where would that spring end up? Where are we heading?

## Private practitioners are 'out there'

The phrase "Lost in Translation" is catching on recently, not only because of the Bill Murray comedy movie by the same name. In 2003, Claude Lenfant delivered the 113<sup>th</sup> Shattuck Lecture on "Clinical Research to Clinical Practice – Lost in Translation?" He described how despite the burgeoning amount of medical knowledge that is gained, not that much actually arrived at the patient's doorstep to corroborate the research impact. There is no denying that the same is also happening here as well. However, there is another dimension that seems to be lost in the delivery of health care at ground zero Singapore. This was somewhat demonstrated during the feedback session that followed the seminar on Transforming Primary Health Care mentioned earlier.

The major question that was raised at that seminar was essentially: How do you organize the private GPs, especially the solo practitioners to participate in quality assurance or team care? The responses from the participants varied: there was a general admission that this was a difficult task, the most often quoted reason being "lack of funding"; some of

the group practices have allocated funds for their own in-house programmes, and one has even developed its own service code or philosophy. The common sentiment though was that there was little hope in waiting for "hand-outs".

It was then that a solo practitioner asked: *"how can the solo GP, with his limited resources and time, be expected to do all these audits and analysis?"* On the surface, this sounded much like asking about the same things. However, the doctor added that he did not expect an answer for he knew how difficult the situation was. The responses were indirect. One suggestion was to think of quality as a critical part of providing health care – the sharper the tools, the better the outcome. Another involved the need for GPs not to under-price as this behaviour runs counter to good quality practices. One participant even suggested using legislation to prevent under-pricing.

On reflection, the 'question' was not really begging for an answer. It was more of an expression of the solo practitioner's predicament and his concern, which I will guess was probably not far off what many other private GPs might feel. But the fact that the responses could not address his problem pointedly perhaps was more telling. There is a cliché statement that "GPs play an important role in ... (healthcare services)" – usually used in the context that they have to fulfil some kind of standard. That they are important is not an understatement because private GPs make up 80% of the primary care doctors. But where exactly are they figured in the provisions to deliver that all-important service, when compared with their institution counter-parts?

Perhaps then, the most appropriate response to that doctor should have been: *"We ought to know more about YOU"*. Many attributions can be postulated for not having done so, such as "GPs are a diverse group and difficult to generalise", or even truthfully "the private sector cannot be our concern", or just "you were not in our sights", but essentially, it comes to the same – the processes, funding and programmes

Page 10 ►

somehow fail to reach them, or in another manner of speaking, they are 'lost', somewhere out there.

### Lost, but staying alive

This loss is not simply about overlooking a part of a simple equation or balance sheet. Somehow, I felt myself being drawn towards the analogy of a 'neglected child'. We know for a fact that family medicine as a discipline has been sidelined for a long time, till recently. Until recently, generations of medical students have trained under programmes that did not emphasise efficacy of the GPs. Vocational training even now is voluntary and involves mainly the younger generation of doctors. It is not a surprise then to see why some colleagues in the other disciplines who were cast in the same mould, do not take GPs seriously.

Fortunately, most of the private practitioners even when left "out of the loop" or "lost" do adapt themselves to the realities of private practice. However, many of such adaptations are based on so-called "short term market forces". While some of these, which include under-pricing, long working hours and shorter consultation times, might not seem consistent with "quality practices", it has to be remembered that these are but responses in the name of survival, with whatever knowledge of health economics and practice management these doctors have at hand. In fact, some has become quite affluent from their practices. Therefore, to change the very principles that promoted 'success' or survival is understandably a difficult task, if not unthinkable.

One of the difficulties mentioned in the seminar was prevention of under-pricing. This was curiously linked to the issue of self esteem. Here I contend that if there was ever poor self-esteem among GPs, it might have come from systematic neglect during the formative years – the behaviour of under-pricing is more likely to be a situational reaction rather than the cause of low self-esteem, although it is one that can perpetuate the problem.

Left to their own devices, most GPs try to make sense of their predicament by constructing their own philosophy and

meaning about general practice or the practice of medicine for that matter (much like how one participant developed his service philosophy for his group practice). Altruistic calling in life or business, lavish clinic with state of the art equipment or low-cost set-up, 'true-blue' clinical medicine or aesthetic clinic, each of these approaches represent the different ideas, expectations and expression of medical practice that have evolved in the given environment. Sometimes these styles are conveniently under the guises of personal styles of practice.

Standardisation of practices, which was mentioned in the seminar, was never quite a necessity, nor even desirability in small practices in competitive neighbourhoods. To impose them, even though it sounded like the right thing to do (or worse, just because one has been given the authority to do so), would inevitably provoke resistance, not only because the private practice has become a personal articulation of self-found efficacy, but it also leaves mixed or ambivalent feelings, much like a child who struggles to grapple with the commands from the parent who had forsaken him in the first place.

### Identifying with the child abuser

It was also commented at the feedback session of the same seminar that graduates of family medicine programmes do not return to help the college. This is not surprising in the neglected child analogy because it may well represent an example of "identification with the abuser". This is an important process in the intergenerational spread of abusive behaviour, where the abused child of a generation becomes the abuser in the next generation. It should be notable that the corollary of the oft-heard dictum "*nobody owes you a living*" may easily be "*I don't owe you anything either*". But it is saddest when one who has suffered contempt would eventually show contempt to his fellow colleagues.

At this juncture, some may argue that the analogy is not appropriate because the private practitioners are not "*children*", and "*as professionals, they should know better*". I agree that some people do

conquer the unfavourable influences of their formative past. Yet, it does not take much to notice that within each and every one, there are parts of the formative past, good or bad, that obstinately manifests in our speech, decisions, behaviour and mannerism. The "child" never really leaves us. Moreover, the belief that "people should know better" is a stance that prevents further any understanding of the problem.

### Engaging the private practitioners

So what if we understand the neglected child model? What is the significance of the model? Firstly, it helps understand the problem as upstream, during the formative years of the doctor. While time and exposure in the curriculum is important, it may be even more crucial to inculcate the sense of self-efficacy of the GP, not only among family medicine students but also among students of all the medical disciplines.

Secondly, it is a point in humility to remind ourselves of the Winnicottian concepts that "*there is no such thing as a baby – only a mother and a baby together*". One cannot comment on the state of affairs of the private practitioners without reflecting on the institutions that produce them or the policies that perpetuate their behaviour. There is little constructiveness in being judgmental, unless the policy makers are prepared to judge ourselves.

Thirdly, engaging the 'neglected' GP is the same as engaging a neglected child. It must be done in their own terms, at their pace, and with their concerns in mind. And the engagement must be built on TRUST. Pushing for change in the name of quality only repeats the processes of neglect and abuse.

Fourthly, the model emphasises the need to put personal faces to the problem. The statement that "*they are grown-up professionals and they ought to know better*" has long been used out of context and even abused to depersonalise the issues and absolve responsibilities. With the clamour for patient- or client-centred management, it is only consistent and congruent that we also consider the private practitioners as the 'clients' in the quest to transform primary care.

Clinicians who are familiar with helping patients with behaviour change will realise that establishing relevance and importance for the patient may likely result in patient-initiated changes, in contradistinction to blanket regulation and ineffectual enforcement. The SARS episode demonstrated that GPs are not different from patients in that aspect – relevance, importance, support and feedback were the key ingredients of their success.

**And finally and if not most important, it must not be misconstrued that the solo or private practitioner of the present or those of us who have gone through the ‘neglect’ should smugly become the passive ‘victim’. Perhaps it is about time that we differentiate ourselves from the unproductive relationship issues of the past and forge a more**

**meaningful one as a responsive ‘parent’ to the future generations of general practitioners.**

#### Looking (Out) Ahead

Is this article a plea to understand private GPs better? Yes, but only in two conditions. First, it is true in so far as to ensure that partnerships can be built that will activate the formidable “third force”, which will undoubtedly benefit primary care in Singapore. Second, it is a plea for the private GPs to understand **themselves** more and establish themselves in the scheme of quality health care delivery in Singapore, if only for the sake of the ultimate end-users – the patients and their families.

The metaphorical iceberg therefore applies to all, and it is up to the reader to find out what it represents to him or her,

bearing in mind that even if just the tips are appreciable now, they are significant. To some, it may represent ‘engaging private GPs’; to others, it may represent ‘engaging the health authorities’; and yet to others, it is about ‘emotional baggage of the past’. Whatever it is, no matter what superior ideas we have to transform primary health care with; or what sophisticated technology we have to translate into practice; or simply as proud captains of our own destinies in medical practice, we should start to pay heed to it. Otherwise, like the ill-fated Titanic, the iceberg will yet again move right along...”as though NOTHING had happened”.

*The views of expressed in this article are solely those of the author and do not necessarily represent the opinion of College of Family Physicians Singapore.*

### PRACTICE BASED RESEARCH NETWORKS

GP practice based research networks can shift from the role of primarily collecting data for research undertaken through the primary care setting. GPs can be more involved in the development, conduction and interpretation of research, in addition to their collection role (Gunn, 2002).

Practice based research networks around the world have contributed useful pointers on making these work. The following have been demonstrated to be important (Gunn, 2002):

- Research networks should have explicit aims about what is to be achieved – encourage evidence based practice, small scale practice-based research or large scale interventional or longitudinal studies;
- Research networks bring interested people together – opportunities for collaboration
- Networks should have academic links – in order to have easy access to suitably qualified researchers
- Networks should complement other capacity building initiatives – collaborative and complementary activities amongst networks, academic institutions, and research bodies.
- Research networks should be realistic about what they can achieve – Setting up a network that tries to achieve progress in many areas is unlikely to succeed.

- It is worthwhile considering the optimal size of a research network – The Dutch experience shows that small groups of practices with skilled GP researchers can achieve considerable outputs, such as publications and higher degrees.
- Evaluation and monitoring are essential – the network’s objectives, strategies and activities.

#### SUPERVISING RESEARCH STUDENTS

Deborah Saltman has worked out a model matching research student & supervisor leadership styles. The learner is found to go through four development stages (D) in the process of mastering a new task.

These are: D1 – enthusiastic beginner; D2 – disenchanting learner; D3 – capable but cautious performer; and D4 – self reliant achiever. The match supervisory style (S) should be correspondingly: S1 – directing; S2 – coaching; S3 – supporting; and S4 – delegating (Saltman, 2004).

#### WHERE DO WE GO FROM HERE?

##### Asia Pacific Mission & Objectives

For each country - the 3 initial tasks are suggested

- Get ideas across-AP research network development workshop in March 2004
- Set up the AP country nodes – through AP country representatives by end 2004
- Provide answers to clinical questions for family physicians – a physicians’ clinical Q & A database in GFD by 2007

#### For each family physician

- View yourselves in the FM research endeavour – user, researcher, research developer
- Users think about stating your clinical research needs & use the system to help your practice
- Researchers think about the FM Research Domain Classification for questions to answer
- Research developers think about the roadmap to build capacity in FM research

#### TRACKING RESEARCH STRUCTURE, PROCESSES AND OUTCOMES

Key performance indicators to track research structure, processes and outcomes are:

- Development of capacity at national level - Number of doctors participating in FM research; Publications; Implementation of results in practice
- Research centre performance - Best Practice, training, research output, Leadership role, Enabling role, Disseminating role

#### Reference and further reading

Stange KC, Miller WL, McWhinney I. Developing the knowledge base of Family Practice. *Family Medicine* 2001;33(4):286-97. Gunn JM. Should Australia develop primary care research networks? *MJA* 2002; 177(2):63-66. Saltman D. Supervising research students in primary care using a leadership model. *Aust Family Physician* May 2001;33(5):1-3.