# Maintaining Relationships, Transforming Primary Healthcare

by Dr Irwin Clement A. Chung Wai Hoong, MCFP(S), Editor

My granny was recently admitted into an acute hospital after a "near fall" during which she sustained a Colle's fracture to the left wrist while trying to avoid hitting the ground, quite fortuitous in a sense as she is severely osteoporotic in the hips. The fracture was splinted and she was admitted as she had complained of frequent fainting spells and anorexia. She subsequently went through 2 weeks of rehabilitation at the adjoining community hospital before being sent home.

Naturally, at times like these, my relatives would turn to the only doctor in the family (alas, that's me) with every conceivable query at every opportunity and whenever her condition changed (for better or worse). "Oh, granny is still feeling faint. Why like that?". "She does not seem to eat as much today as she did yesterday; is she sick?". "The doctors say her potassium level is low; is she having kidney problems?". "Her feet are a little swollen; the doctors say she is not moving them enough, but I think it is organ failure. What do you think?". "I don't think mum will live beyond 2 weeks…" (Flabbergasted) "Her fingers seem less swollen now after changing the cast. Is that to be expected?" (Dumbfounded) The burden of relationships... I need to give my ocular muscles a break from eye-rolling.

Anyway, granny is at home now, her usual perky self, frequently admonishing her helper for not doing the chores exactly the way she would have done them, complaining about the living aids we installed for her – grab bars, ramps, non-slip mats, extra lighting, the works – and hitherto showing no signs of heading into another realm either above or below. And she is also very stubbornly refusing any more interventions other than what is considered basic and necessary, which she can get by going back to "her polyclinic doctor". Okay, so there is a silver lining to this. I am quite glad that she recognises the polyclinic as her "medical home" (to borrow American terminology) to which she can turn for basic but accessible and holistic person-centred healthcare.

That good primary care is the bedrock of any successful and sustainable healthcare system in any kind of economy is undeniable. But it is not just about building healthcare that is "better, faster, safer, cheaper", as what makes primary care tick is really that opportunity for and culture of delivering person-centred healthcare that is squarely centred on building a relationship of trust between provider and recipient. It is this relationship base that can traverse and at the same time support any gain in medical knowledge, process improvement, efficiency in delivery and evolution of healthcare modelling. Take away that opportunity for relationship building and primary care will crumble to the ground. This is a value of primary care that all, from policy makers to funders to practitioners, ought to safeguard and preserve with great fortitude and sometimes heroic effort. And realistically, it does not always come "cheap". Primary care that is not a production line for seeing cough and cold cases, or issuing medical certificates, needs significant investment.

One of my current projects at work now revolves around upping the ante on primary care delivery to the community, by bringing back elements of primary care that have so woefully migrated over the years into secondary and even tertiary care. I am speaking of managing people with metabolic risks, with the need for better weight management. I am also speaking of women across all ages that have the need for regular gynaecological risk screening, post-delivery care and essential sexual health. It could also looking at care for children with common allergic conditions that do not require or benefit much from extensive (and expensive) allergen testing. Not forgetting the elderly who simply are living with great inconvenience from poor vision and hearing, who need simple visual assessment with a view on cataract surgery, screening for those at risk of medically manageable glaucoma, and audiology assessment for hearing aid fitting. Yes, a plethora of roles that (surprise, surprise) a GP would be doing in a good number of healthcare systems around the world.

The Ministry of Health has renewed its push for more care to be delivered outside of tertiary institutions in and by the community. It behoves primary care to step up to this challenge, be it in private sector or public service. We find ourselves once again in the limelight, shifting paradigms and changing established norms to meet the increasing need for affordable and accessible care. It's a mission we can ill avoid, because many times when our patients run out of options, or are absolutely perplexed by the complexities of specialty care, they simply turn around back to the comfort primary care. "My GP will know what to do."

Let's hope we do.

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