

## FROM THE MEDICAL CHAIR



# NHG Partners

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General practitioners play an important role as gatekeepers to specialist care by treating cases, wherever possible, in the community and referring only those that need further investigations and specialty treatment. This helps to control overusage of specialist services and escalating healthcare costs. However, the emphasis on specialisation and subspecialisation in the past decade has opened up direct access to specialist care and patients today can walk in to see a specialist, albeit at private rates. The focus on medical advances in public education has, to some extent, steered patients towards early specialist treatment as opposed to seeing GPs first.

The relationship between hospitals and GP practices has become more business-centred, with hospitals encouraging GPs to refer cases to their specialist clinics and discharging cases that specialists did not wish to follow up. Current funding mechanisms do not favour the latter and many patients ended up stuck in a hospital-based healthcare system.

Over time, a gap seems to have grown between the specialists up on a hill (most hospitals were built on hills, though hardly noticeable in Singapore) and the GPs in the valley. Patients end up lost between the two – GPs do not know what the specialists have in mind, and specialists do not know what medications GPs have prescribed either.

Several attempts are now being made to bridge this gap, though we are still a long way off. Much has been mentioned of Electronic Medical Record Exchange (EMRX) eventually being made accessible to GPs though this is yet to be a reality. Indeed when this is possible, GPs may be able to access discharge summaries, investigations and medications dispensed. However, the reverse should also be true and specialists ideally should also be able to access GP's tests and medications. This, for the moment, is probably not on the near horizon. For a start, community hospitals can now access electronic records of patients referred to them by restructured hospitals, but the reverse has not taken place.

Recently, family medicine units and clinics have also been introduced into hospitals. This is an appropriate move and will help to remove the idea that hospitals are only for specialists. Various hospitals have adopted different approaches, from letting GPs run clinics in hospitals to assisting with discharge planning in the wards. Most models currently involve GPs employed on a full-time basis as resident physicians. This, however, may not be attractive to those who may be concerned with returning to GP practice in the future and find it is too late in the careers to find a clinic and restart a practice.

Perhaps another model to consider is for GP groups to employ an extra doctor in their practice and rotate each other to run sessions in hospitals with specialists. They could work in diabetes centres, cardiology and other clinics once a week. They could also rotate through different disciplines every six to 12 months. This would allow them to keep in touch with hospital practices in various settings and in turn strengthen their own GP practice. It would also help patients transit from hospitals to GP clinics as they follow the GP.

More innovative ideas are needed to bridge the current gap between hospital and GP practice. For patient care to be well integrated, information and clinical care must flow in a continuum. This has to be supported not only with IT, but with better face-to-face interactions between specialists and GPs. Funding mechanisms will then have to be modified to help make this possible.

