A New (old) World

The usual hustle and bustle of Monday morning at the GP practice ensued as patients who had waited out the weekend in varying degrees of discomfort started filing into the waiting area. Such scenes can be found in most GP practices across the country given their current pressures, however it seemed to be particularly evident in the practice where I spent my final year GP rotation. Wooler, a small rural village sat on the northern border of Northumberland, is an hour's drive from the nearest emergency department and the population is mostly comprised of farmers, welders and stoical elderly retirees. (I stress 'elderly' as many continue their very manual jobs well into their eighties). I quickly learnt that such patients are more likely to bandage their own stress fracture and continue with their daily five mile hikes than be persuaded into an A&E department for an X-ray.

Suitably, this Monday morning had us out on a home visit to Mrs Archer*, a 95 year old lady who lived alone and was fiercely independent. Following a recent hospital admission she had been persuaded into allowing carers to visit twice daily, on the basis that it would not be safe for her to return home without such a package of care. It was in fact a carer who had called the GP that morning to ask for a review as Mrs Archer seemed 'not her usual self'. When speaking to her carers later on, I discovered that Mrs Archer would never let them do anything for her when they visited (stating that she wasn't in need of their help anyway). Mrs Archer has no children of her own and her two nieces live a short distance away in Alnwick although she seemed reluctant to involve them in her care, stating that she 'didn't want to worry them'.

Wooler is a small village and my GP, Dr Brown*, had made this trip before. Indeed, I noted that is was rare for him to ask Jackie* at reception for the address of his house-call patients as he knew them well already. It took only 5 minutes to arrive at the house and Dr Brown gave a short rap on the front door and then, to my surprise, turned the handle and let himself straight in, saying 'it's the doctor calling Mrs Archer'- needless to say I felt like we had stepped 50 years back in time. I was busy trying to think of the last time I had walked into someone's house uninvited, when he waltzed his way into the living room! The room was small with only two armchairs and an array of porcelain ornaments lined up across the mantelpiece. Despite this it felt very lived in and certainly looked like Mrs Archer normally managed very well in her own home. We found our patient sat in her chair by the fire looking short of breath and tired despite claiming to be 'only a little breathless doctor – nothing to worry about'. It appeared Mrs Archer's heart failure had worsened once more and could not be managed in the community. For Mrs Archer this news was more distressing than I had anticipated and was met primarily with flat out refusal and then with protests involving a hair appointment later that day that really couldn't be cancelled. At this point I was convinced that Mrs Archer would refuse to leave her house and I knew that without treatment her condition would likely take a dire turn for the worst. Dr Brown patiently listened to Mrs Archer's concerns, held her hand, explained the urgency of her situation and gave reassurances about cancel her hair appointment. And with that, Mrs Archer finally agreed to her paramedic escort to hospital. In that moment I knew that Dr Brown had very likely saved Mrs Archer's life: with a little medicine and a lot of communication.

I returned to review Mrs Archer one week later when she was safely back from hospital and looking much brighter. Along with her health so too had returned a sharp wit and a thorough

dislike for time-wasting: I had hoped for a nice chat over a cup of tea about her family or her past occupation, however Mrs Archer had a busy schedule that afternoon and I was not included. Mrs Archer was one of the many older people that I met in Wooler who seemed nervous of attending hospital – not because of an association with pain or the noisy unfamiliarity of it (although no doubt that plays a part), but because it signifies one step closer to losing independence. Or perhaps it is the not-unfounded fear that once in hospital, they may never be able to come back home again or even really be asked what it is that they want.

There are many question marks hanging over the future of general practice: will there be a place for small practices, for rural GPs, for house visits, for 20 minute consultations? Are there enough resources for our ageing population? What cuts can we make and where? Whilst trying to solve these puzzles, I am scared that we might as lose sight of the people behind the wrinkles, the knowledge stored behind the cataracts and the strength once possessed by those arthritic joints. I don't know at what point people lose their drive for independence, their feeling of self worth and their thirst for life – certainly Mrs Archer, aged 95, hadn't. However, it can be so easy to dismiss the elderly, delirious patient on the ward: throughout my years as a medical student I would be lying if I said I hadn't witnessed such practice. I was fortunate enough to see a different approach to elderly care when on my GP placement. I experienced doctors going out of their way to help patients maintain some independence, witnessed non-patronising conversations about their health and care needs, saw the genuine empathic response of GPs trying desperately to keep their patients out of hospital but sometimes needing to emphasise its importance.

I only hope that the structure we end up choosing allows us to keep some of the old gems of general practice, perhaps preserved best in rural areas, as well as taking us into a future of good, sustainable care for our elders.

*names changed

Leola Cruden Smith
Final Year Medical Student
Newcastle University