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You will now forgive me if I wax lyrical for a while .. it is, however, the last time you need to endure this…

In 1999 I joined the practice as its first GP trainee. I asked to come to the surgery given its reputation then. I had fantastic mentors and role models in the partners at the practice at that time. I had rather side-stepped into General Practice having initially spent six years in hospital, aiming for a career in hospital medicine but for a variety of reasons became somewhat disillusioned with that career path. I was introduced into a professional world that was rich and varied – it had a breadth to it – we looked after people from cradle to grave but also a depth that I had not anticipated, where patients could present with a complex mix of psychological, social and medical factors – all intertwined with one another and the challenge for the doctor was to unravel this and navigate a path through these problems.

When I started it was very much a traditional model of general practice- 4 partners. We did our own on-call at night and at weekends. Life in a rural practice was different, being a bit of a townie. Roused in the middle of the night from a warm bed to visit patients in Lower this and Upper that or Little or Greater whatnot, no SatNav , helpful addresses such as the Barn or Ivy Cottage- we relied on tea towels being tied around the garden gate to avoid waking the wrong person. We did our own palliative care in the middle of the night. But visiting patients in that out of hour period was an enriching experience , seeing patients in the depths of the night at their most vulnerable created bonds with the patient that remained in memories. There was often the further reward of driving back home through the Cotswold countryside coming alive at sunrise.

We did Saturday morning surgeries. We had two community hospitals in Bourton and Moreton. We admitted and managed our own patients in those hospitals. All of us, after morning surgery, driving to the Hospitals to review the patients. We covered the MIUs. There were numerous consultant outpatient clinics and we could pop over to these and ask the consultant to come and review the patient with us on the ward.

There was a real sense of wrap around care orchestrated by us.

We went out to emergencies and stayed with the patient until the ambulance arrived, and it did arrive, always in a timely fashion. I would go to road traffic accidents to help the ambulance service.

It all added to the vigour and vitality of our professional lives.

Co-located at our little surgery overlooking the Evenlode valley were the district nurses, the health visitor and the community psychiatric nurse. No email or proforma to refer a patient to them , just a wander down the corridor to have a chat.

As I say, a vibrant and rewarding professional life that really I had stumbled upon.

Against the background of what I have just described for you, it's perhaps difficult for a small part of me not to be a little cynical now. Times changed and systems changed sometimes driven by questionable evidence. With change can come inertia that can act as a barrier to patient care. Health authorities gave way to a succession of acronyms – Primary Care Groups – PCGs, Primary Care Trust -PCTs, Clinical Commissioning Groups- CCGs and now finally an Integrated Care Board ICB and I can only look back and think of that little surgery on the corner of Stow with us all working together.

The greatest change I have witnessed, however, is the escalating pressure and volume of workload that we are experiencing in recent years. It is too simplistic and perhaps too self-forgiving for disingenuous politicians to blame the pandemic. A storm has been gathering for sometime. What are the reasons for where we now find ourselves now, in the eye of that storm?

Firstly, we have an ageing population and our practice population is significantly over the national average for patients over the age of 85. The management of elderly people is complex and challenging with individual patients having a range of condition, polypharmacy and complex social care needs – there isn't a quick algorithm or guideline that can be applied to the management of these patients

Secondly, so much care has been devolved from secondary care, hospital medicine, to primary care. Management of long-term conditions that was activity that was held in secondary care is now our responsibility, patients are discharged earlier with the ongoing acute management of their condition also falling to us and in the case of many elderly patients, little attention to their social care needs upon discharge – perhaps the unkindest and most inhumane manifestation of health and social care pressures. We are now in an era

of subspecialists and the true consultant general physician no longer exists who can navigate the complexity of a patient with multi morbidity, who doesn't fit neatly into one single condition pathway and requires a holistic patient centred approach.

Thirdly there is a recruitment crisis ever growing in general practice with middle aged partners choosing to retire or work part-time, jaded by the demands of the job. The new generation of GPs choose to work less than full time or have portfolio careers and thus in real terms the effective workforce contracts – one new sessional GP will not do the work of a traditional full-time partner.

Lastly, and I think this is significant there has been a shift in society in terms of people's expectation in how they access care. People want ready and immediate access to services - they want similar accessibility to their doctor that they have to online shopping or on-line banking and there has been an expectation for us to meet that need. These different modalities of access, online consultations etc has lowered the threshold by which patients will contact us and these are all workflows for us- time still can heal for many conditionsas it always has.

The pandemic forced us, for infection control reasons, to move to more telephone consultations. But that was always going to be necessary, given the pressures I've outlined- the pandemic accelerated what was going to be inevitable to cope with demand, that would not be met through a reliance on face-to face consultations alone.

I think this is somewhat sad for us and difficult for patients as a type of transactional medicine has emerged - the need for high throughput has resulted in patient's having the needs met as consumers of a service in formulaic, time efficient and functional manner. This is OK for some but not for many, I know.

There have been challenges for us, as a practice, but each morning we open the doors to embrace the rich tapestry of human life and the achievement is in keeping going. We fought for the community to have a new surgery, perhaps a surprisingly challenging fight but we kept going. We kept going through a global pandemic. We keep going under the burden of the pressures that the NHS faces, as a whole, where demand outstrips the capacity and leads to a transactional type of medicine, that I've just described, that we try to resist, knowing that continuity of care is what our patients deserve but is also what restores and sustains us.

But amongst change there are constants- we have continued with an enduring central ethos of family medicine, that I believe is still very much a rich vein that runs through our practice and that will continued to be championed by my wonderful friends and colleagues.

We realise that what we do is not just about the science of medicine but the art of medicine. There is often no pathway or algorithm that will encompass the holistic care of many patients and that the only pathway that we need to travel with that patient is to walk with them through their journey through life.

I'm sorry if I've focused perhaps too much on the challenges when discussing the changes, I have observed, but there it is – this is what I have borne witness to.

Despite these, the decision to leave the practice tortured me for some time. Stow and the North Cotswolds is embedded within me, I was married in a Cotswold village, two of my children were christened in Stow and I even had quite a nasty accident in the surgery car park several years ago. But it is time for new challenges and for more time with my family – you should keep the best of who you are for the people you love.

I am very acutely aware that I have been a fortunate man.

I have experienced and witnessed so much, and it has been so rewarding to be one of the town's doctors. I have many, many cherished memories and as I look back through the lens of nostalgia, I realise how lucky I have been. I have been supported by, and worked with, absolutely fantastic colleagues at all levels and I want to thank them for all the care that they have given to our patients but also to me.

There is no job like this in medicine. It is a true privilege to share in the lives of so many people and I want to thank the patients for sharing their lives with me, memories that will always be with me in my mind and my heart. So thank you. That's it.

Dr Paul Sherringham