have been exchanged with rescue services in other caving areas, especially Devon, Yorkshire, and Derbyshire. The Derbyshire people had perfected rescues from long mine tunnels with vertical pitches of two or three hundred feet. They were horrified by our carrying sheet and donated to us a rigid stretcher which would not fit into many of our caves. The radio link is perhaps our most ambitious acquisition, and its use in the sleet on Mendip in November last year alone justified its purchase.

Some memorable rescues

A few rescues seem to stand out in one's memory. We wondered for years how we would cope if we had to bring a victim back through the sump. When it happened—a broken leg some 300 feet (91·5 m) beyond the sump—it was very easy. We have been expecting to have to manage medical emergencies that occur underground. Some years ago a diver on a rescue in the United States had a myocardial infarction. A few months ago we had a similar episode on Mendip. It was only 200 feet (61 m) inside GB cave. An apparently fit 33-year-old man on his first caving trip complained of chest pain and collapsed. He was quite dead when I reached him. We had wondered how young and inexperienced people would cope emotionally with the recovery of a corpse, but again our fears were much worse than the reality and his colleagues, with minimal experience, had already tried mouth-to-mouth breathing and external cardiac massage.

Another incident occurred in South Wales on a pleasure trip through Ogof Flynnon Ddu. We encountered a distraught caver who said there had been an accident and did we know where help could be obtained. Our party had three of the Mendip rescue wardens and one doctor but no rescue equipment. The patient was a girl who had fallen off a ladder and suffered a compression fracture of a dorsal vertebra; an air of confidence seemed to work wonders, and when a stretcher was brought down she was quickly taken to the surface by the South Wales rescue team. There was also a large school teacher who at the last minute decided to help his son's friends explore the tighter parts of Swildon's and became firmly wedged, head down, in a canyon passage. Nobody could get anything under him and by the time MRO arrived he had long since ceased to care. Attempts to winch him out backwards produced the awed comment that his joints were going like fire crackers, but options were few by this stage. Somehow he was removed, and the next we heard was that he had approached his own doctor to seek advice about suing the MRO for a minor degree of paralysis in one arm.

On another occasion we were called when a serviceman had fallen in Swildon's and was thought to have broken a leg. At the entrance we were told it had been splinted and he would soon be out. Having nothing better to do that afternoon I went down and was surprised to find the splint consisted of a 3" plaster bandage around the fracture site. A boy sailor in Goatchurch had been sent into the tunnel at the bottom because it was thought to be character building. There he became unconscious. He smelled ketotic, and I thought he might well be an unrecognised diabetic but he was pulled out backwards and sat up and he went out under his own steam. His blood sugar was estimated in the casualty department in Bristol and was normal.

Fred's boot

From time to time we see people who go down ladders or through sumps and refuse to return. In dealing with these the technique known as "Fred's boot" has been used with success. Fred Davies is a caver of great experience and he can be relied upon to assess correctly the victim who can help himself and will not. Fred's boot is thought to be endowed with magical properties and has worked well on several occasions. Where real injury has occurred, confidence and sympathy plus some hot soup and glucose tablets are much more useful.

Some rescues have not been without an element of farce. Two Army officers let it be known they were going caving on the Mendips and went absent without leave. Every cave on Mendip was searched before they were discovered. A full call-out was arranged to search Stoke Lane Swallet when a car containing caving clothes was found in a lay-by near the cave. The missing man was found by police painting the inside of a nearby caving headquarters. A group in Swildon's Hole mistook the route from a high level passage and abseiled down into a blind pot, pulling the rope down after them. Fred was the first to reach

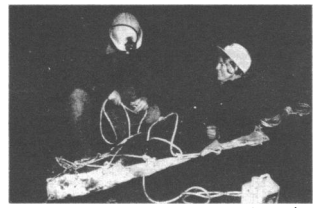

FIG 2—Lacing up the victim in the carrying sheet on a practice rescue from Goatchurch Cavern.

them and refused to throw them another rope until they had admitted their stupidity and apologised for the trouble they had caused.

Cave rescue workers have considered their attitude towards accident prevention. While we are prepared to pass comment when people are stupid, when they use dangerous tackle or unsafe belays, we think it would be wrong to overprotect. In Mossdale in Yorkshire some years ago the cave entrance was closed after six cavers were drowned in a sudden flood. It has been suggested that all that was done was to close the safest exit.

Caving offers an escape from too much of society's control, and it would be a pity to restrict this.

Of Anger.

THE paffion of *anger* ruffles the mind, diforts the countenance, hurries on the circulation of the blood, and diforders the whole vital and animal funftions. It often occafions fevers, and other acute difeafes; and fometimes even fudden death. This paffion is peculiarly hurtful to the delicate, and thofe of weak nerves. I have known fuch perfons frequently lofe their lives by a violent fit of anger, and would advife them to guard againft the excefs of this paffion with the utmoft care.

IT is not indeed always in our power to prevent being angry; but we may furely avoid harbouring refentment in our breaft. Refentment preys upon the mind, and occafions the moft obftinate chronical diforders, which gradually wafte the conftitution. Nothing fhews true greatnefs of mind more than to forgive injuries: it promotes the peace of fociety, and greatly conduces to our own eafe, health, and felicity.

SUCH as value health fhould avoid violent gufts of anger, as they would the moft deadly poifon. Neither ought they to indulge refentment, but to endeavour at all times to keep their minds calm and ferene. Nothing tends fo much to the health of the body as a conftant tranquillity of mind.

(Buchan's *Domestic Medicine*, 1786.)

Pitfalls in Practice

Finding a practice

I: The adverts

JOHN OLDROYD

This article is based on an audiovisual presentation made for vocational trainees in general practice by the MSD Foundation.

Dr Ian Keen was ready to put all his expensive training to use in the service of the sick. The time had come for him to apply for a position on a family practitioner committee (FPC) list. He wanted to use all the skills that he had learned, polished, and honed during his life since O levels, culminating in his soon-to-be-completed vocational training. If you are in the same position you'll realise that good partners are as difficult to find in general practice as in other walks of life.

Dr Keen's sense of vocation was tempered by the increased responsibilities of his recent marriage and the thoughts of children and their needs. He was therefore looking for the life-style that his mother had always wanted for him, and to that end he perused the partnership advertisements in the *BMJ* with questing enthusiasm. The range of possibilities seemed wide, and many of the advertisements offered promising prospects.

CHRISTIAN DOCTOR with sense of humour wanted to join 45-year-old single-handed principal with full list in northern industrial town. Early parity giving a gross of £13 000. Outside work encouraged; there is scope for development of progressive practice ideas. Dr Ramsbottom, The Old Unitarian Chapel, Station Road, Illthwaite.

SALARIED PARTNER required by single-handed male principal with above-average list in urban Home Counties north of London. Would suit a lady doctor with domestic commitments who is interested in family planning and maternity work. Remuneration will be generous and determined after resolving the duties to be performed. Box 12345 BMJ.

DO YOU ENJOY the country life? Join us in rural Norland. Early parity, full dispensing, ample opportunity for increasing list size. Opportunity to use your clinical training to the full. Initial share worth £10 000. Apply Drs Grouse & Partridge, Amblethorpe, Norlandshire.

YOUR FAMILY will love living on the south coast of England with its balmy climate. Our two-man partnership has a vacancy for a third partner. The practice has some interesting outside appointments. Salaried partnership £5000 for a period of mutual assessment followed by sharing partnership by agreement. Interested? Then write to Matelot and Smooth, Blue Peter Surgery, Marine Parade, Brighthaven.

AN UNUSUAL type of doctor required by a progressive, forward-looking GP who still considers that family doctoring requires a family doctor and not a primary health care team. Requirements simple and in the following order; compassion, common sense, interest in medicine as a profession rather than as a job, average intelligence (above average not debarred). No overtime payments but salary will be commensurate with qualifications, experience, and personality. Have all the usual: modern purpose-designed premises, open hospital and lab access, nurse and health visitor attachment, full secretarial staff, hospital and outside appointments. Admit to bias against modules, interference over administration and 9-5 mentality. The post offered is as a third partner in long-established family practice. Preference given to graduates with an interest in old-fashioned general practice, in modern context. Vocational training not essential; this can be given in post (senior partner GP trainer). Anyone interested apply with full details. Interviews in Yorkshire, and do not be deceived, I will interview you, not you me. Reply Senior Partner, Waterloo House, Clertheckmondsedge, W Yorks.

THIRD PARTNER to join two established principals in Elysium on Thames. The practice is conducted from owned premises in this market town which has excellent ranges of housing and good schools. Ancillary staff employed, attached health visitor and district nurse. Salary £8000 at start with review. Curriculum vitae please to Drs Sharpe & Idle, Regency House, The Market Cross, Elysium on Thames.

Secretariat for London Local Medical Committees, Tavistock House North, London WC1H 8ET
JOHN OLDROYD, MB, FRCGP, secretary

While many advertisements are exactly what they seem, there are some where it pays to try to read between the lines. What do the above advertisements really offer Ian?

Christian doctor with sense of humour wanted to join 45-year-old single-handed principal with full . . .

Ramsbottom has soldiered in the trenches for as long as he can and is exhausted. He is aware he is behind the times in practice developments—appointment systems, attached staff, and the primary care team—but he is willing to take a substantial cut in income to get help on his own terms, even if it means fighting for a clinical assistantship. It will, however, have to be on his own terms, which means no immigrants and someone who will be a social friend and will share his cynical appreciation of his lot.

Salaried partner required by single-handed male principal with above-average list in urban home counties . . .

"I need someone to give cover for me when I go off on holiday. You will have to do only a basic 20 hours a week in order to get maximum allowances from the FPC. You will take over all the family planning, smears, and maternity work to increase the practice income. The potential is enormous with all the neurotic, lonely, bored commuter housewives."

Do you enjoy country life? Join us in rural Norland. Early parity, full dispensing . . .

"It is pure hell here in winter. The calls are impossible, the hospitals inaccessible. We have to cope. As to deputising services—forget 'em. You will have to go out to road accidents on the motorway. All those isolated villages are crying out for a doctor. Money won't be a problem—time off and holidays will."

Your family will love living on the south coast of England with its balmy climate. Our two-man . . .

"We need someone else to look after all the temporary residents in this geriatric dustbin next year while the present partners are (*a*) cruising as a medical officer on the luxury liners and (*b*) giving a lecture on wine appreciation to tourists in the chateaux de la Loire."

An unusual type of doctor required by a progressive, forward-looking GP who still considers that family doctoring requires a family doctor . . .

"I am a strong personality—can the partnership exist with the two of us?"

Third partner to join two established principals in Elysium on Thames. The practice is conducted from . . .

On reading this, Ian decided he need look no further. This was it. He spent a happy hour or two composing a curriculum vitae that he thought would put his own qualities in the best light and impress the two partners.

This is the first of four articles on finding a practice.

Emergencies in the Home

The psychiatrically violent patient

P W SHORT

When considering the violent and psychiatric patient it is important to remember that the terms "violent" and "psychiatric" are neither interchangeable nor complementary and that they may be applied separately or together. Thus not all violent patients will be suffering from psychiatric illness, nor will all psychiatric patients be violent.

Diagnosis

Having received an urgent request to visit a violent patient, one of the first decisions to be made is whether the cause of the patient's problem is organic or psychiatric. (The general practitioner will usually have the advantage of knowing the patient's medical history, and this will be of great help when making a diagnosis.)

ORGANIC CAUSES INCLUDE:

Metabolic—(1) Ingestion of drugs or alcohol (most of us will have met with the violent drunk or patient suffering from delirium tremens). (2) Hypoglycaemia. Hypoglycaemic patients may be quite violent. (Peter Hall[1] mentions this as being infrequent, but, having an irresponsible teenage diabetic who reacts in this way in my own practice, it is not so rare an experience for me!)

Infective—A typical example of an infection that may produce a violent non-cooperative patient is meningitis.

Organic brain damage—(1) Post-brain injury with reduction of inhibitory centres. (2) Senile dementia—patients may be both violent and uninhibited.

Post-epileptic homicidal episodes

Beckington, Bath
P W SHORT, MB, CHB, general practitioner

PSYCHIATRIC CAUSES INCLUDE:

Paranoid state—Schizophrenic patients, for example, may sometimes progress to violent behaviour as a result of their delusions of persecution.

Psychopathics—By definition these patients are both aggressive and violent and this should be borne well in mind when attending them.

Depressive states—Depression sometimes results in violence, which may be directed outwardly, inwardly, or both (for example, attempting to kill one's child before committing suicide).

Manic depression—Patients in the manic phase of this illness may become violent and may be very difficult to control even when given large doses of tranquillisers parenterally.

Hysteria—May produce violent behaviour, which again may be difficult to control even with high doses of drugs given parenterally.

OTHER CAUSES INCLUDE:

Bouts of plain bad temper or rage. Political acts of violence by "normal" people—although these acts seem to be all too common, they do not often come within the province of general practice.

Management

GENERAL APPROACH

Great care must be exercised when confronting a violent patient who may be very dangerous (an injured or dead doctor only compounds the problem). The doctor must not be seen to be frightened by the patient even if he is. He must be calm and unhurried in his approach. He needs to be willing to talk to and listen to the patient, which may help the patient to calm down—a fact which has been amply demonstrated in various "sieges" around Europe.

DRUGS

When the general approach fails the use of drugs will probably be required, and it is necessary to seize the chance to give them as soon as the opportunity presents itself. (Do not forget that to give drugs parenterally without the consent of the patient is an act of assault, so be safe and commit the patient first.) The following drugs will cover most eventualities.

Diazepam (Valium) 20-40 mg intramuscularly. This drug may have little or no effect on the patient who is already being treated with diazepam; but it is otherwise useful in calming the agitated or hysterical patient.

Chlorpromazine (Largactil) is effective in controlling the patient in an acute schizoid state. The dose varies with the age and sex of the patient—a fit young man will require 300 mg intramuscularly, while 200 mg intramuscularly is suitable for a woman patient. Older patients require smaller doses.

Sodium amytal—This drug may be used with chlorpromazine in treating patients in acute schizoid states or when the patient is particularly distraught. The dose given is 300 mg intramuscularly for a fit young man, 200 mg intramuscularly for a fit young woman, and a smaller dose for the elderly patient.

Haloperidol (Serenace)—This may be used for the patient in an acute schizoid state, but is the drug of choice for manic episodes. The dose is 30 mg intramuscularly for a fit young man, 20 mg intramuscularly for a fit young woman, and a reduced dose for patients over 60 years of age.

Medium-term action

It may be necessary to admit the patient. If a crime has been committed the police remove the person concerned into custody. Otherwise the admission may be compulsory or voluntary.

Voluntary admission—In the case of voluntary admission the main problem seems to be in obtaining admission to a psychiatric hospital, which always seems more difficult than other kinds of admission. If it is possible, however, everyone prefers that the patient agrees to hospital admission.

Compulsory admission—Under the 1959 Mental Health Act (England and Wales) patients can be admitted to hospital against their own wishes provided that the persons signing the section agree that the patient is a danger to himself or others, or both, if allowed to remain where he is. (For Scotland and Northern Ireland see below.)

Section 25 requires the signatures of two medical practitioners on form 3A (obtainable from Her Majesty's Stationery Office, but usually carried by the appointed psychiatrist). One of these may be the patient's general practitioner and the other must be a psychiatrist appointed by the local health authority. This commits the patient to a compulsory admission of 28 days for observation.

Section 29 requires the signature of two people. One of these must be a medical practitioner and is usually the patient's own doctor. The other may be a "friend" of the patient—either a relative or a social worker. The difficulty in obtaining the signature of the social worker is that he may well be off duty, and his deputy may be 60 miles away at the time the signature is needed. To avoid this problem it is worth carrying a personal supply of the necessary form 2 or 3A (obtainable from HMSO) which will enable a relative to supply the second signature (a list of those regarded as relatives may be found on the reverse of form 2). If it becomes necessary to involve the social worker in any way with the possibility of admission of a patient under Section 29 the medical practitioner may claim a fee from the area health authority (using a form obtainable from the Social Services Department). The Social Services may be reluctant to provide one with this form, but do insist, the fee being £16·60 for a general practitioner and £20·10 for a doctor with special experience. It is also possible to claim a mileage allowance. Section 29 admits the patient for 72 hours' observation.

Section 135. Under this section a magistrate and social worker may admit a person to a place of safety.

Section 136. Under this section a police officer may admit a person to a place of safety from a public place.

Obviously sections 25 and 29 are those most likely to affect the general practitioner. The section preferred will vary from area to area. In my area the psychiatrists dislike using Section 25 and the social workers dislike using Section 29. This makes compulsory admission very difficult on the rare occasions on which it is considered, but the Act allows a relative to co-sign Section 29 (form 2 or form 3A may be used) with the general practitioner. The social workers discourage us from using this method, saying that it is not in the patient's best interest. The disadvantage of compulsorily admitting a patient to a psychiatric hospital with "open" wards is that the patient may easily walk out again, sometimes within hours of having been admitted.

Conclusion

While it may not be possible to provide a cure for these patients, much can be done to try to prevent a recurrence of the acute violent episode. The general practitioner is in an ideal position to facilitate a change in attitude and management on the part of the whole family at a level they can understand, which should contribute to better control of the underlying condition—for example, once the family of a schizophrenic patient fully understand the importance of regular medication in the prevention of relapses they may be able to persuade the patient, who is often very reluctant to continue his long-term drugs, to take them regularly. It may also be possible to explain to the family that the reduction of tensions and pressure on the patient will cause fewer relapses.

Scotland and Northern Ireland

Scotland and Northern Ireland are covered by different Acts, but there is no difference in the intent of the Acts. The relevant sections of the 1960 Act on Scotland are Section 23, which is equivalent to our Section 25, and Section 31, which is equivalent to our Section 29. Sections 135 and 136 are represented in the Scottish Act by Sections 103 and 104. In Northern Ireland the 1961 Act can be invoked.

My thanks to my wife Susan, Mrs J Gould, and Mrs A Lacey-Hulbert for help in preparing this paper.

Reference

[1] Hall P. Notes on the management of psychiatric emergencies. *Update* 1978; **17**:933-40.

Oddity remembered: top secret

I was born before the first world war in the village of Trecynon near Aberdare. My father was the local doctor, and most of his patients were colliniers. During the long lockout of the miners in 1921 the people suffered great poverty. My father's relative wealth isolated my brother, my sister, and myself from the other children. Children's play was the one activity that brought us out of our isolation: playing with tops and hoops, high backs, leapfrog, hop-scotch, and dickdown (jackstones in England). About 60 years ago I was playing with my top in Trecynon Square with a group of other children and whipped it through the window of Mrs Evans's sweet shop. She had a ginger cat who slept inside the window; I missed him. All the children ran away so Mrs Evans did not know who had smashed the window.

Some years later I was called to see Mrs Evans's grandson who had pneumonia. By then we were using sulphappridine, but Mrs Evans had other ideas, for, in spite of the stench produced in the bedroom, she had put a sheep's lungs at the patient's feet under the bedclothes. The principle on which her treatment was based was that if the sheep's lungs rotted rapidly it meant that they had drawn the infection from the child. The child recovered so Mrs Evans and I both claimed the credit.

After another 20 years had passed Mrs Evans herself became ill. This time, at last, after 40 years I confessed that I was the little boy whose top had smashed her shop window. But at 90 years of age she died for my medicine did not work and no one tried a sheep's lungs.—ALISTAIR WILSON, general practitioner, Aberdare.

We will be pleased to consider for publication other interesting clinical observations made in general practice.—ED, *BMJ*.

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