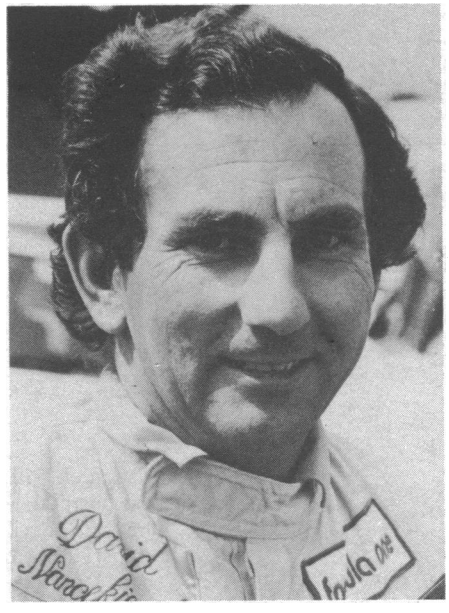
In and Out of Medicine

Busman's holiday

Shop plus shop equals shop, but shops range from the sterile supermarket with neatly packaged food on a quiet weekday to the noisy market shop on a busy Saturday. David Nancekievill's life varies in much the same way—from consultant anaesthetist in charge of intensive care at St Bartholomew's Hospital (where he spends most of his time putting people to sleep) to medical officer in charge of track rescue at Brands Hatch on Saturdays (where he revives them). He is chief medical officer to the British Racing Sports Car Club (BRSCC) based at Brands Hatch, chief medical officer at Chase Water Power Boat Club in Staffordshire, and chairman of the London branch of the Accident and Emergency Medical Technicians (the AEMT are the paramedics on many London ambulances), and he is on the Royal Automobile medical panel—all this in his spare time, and for no pay. So much for leisure.



David Nancekievill

Dr Nancekievill's extracurricular career began when, as a medical student in 1960, his passion for racing cars and his desire to escape from medicine (and beer) took him to racetracks; he hoped, too, to do a little driving himself. To this end, he offered his services as a marshal to the British Automobile Racing Club at the GLC Crystal Palace circuit, started somewhat inauspiciously by looking after the ladies' lavatories, then became a marshal, a flag marshal, and ultimately an observer (a senior official). He found this relaxing, enjoyed being away from medicine, and learnt a lot about racing cars. Soon after he qualified in 1964, however, he was asked one day to act as a doctor instead of as an observer, and from then on he was gradually dragged into regular doctoring at the tracks. After a time, David Nancekievill realised that the medical side of things was fascinating and ever since then has been happy to devote his free time to this pursuit, which takes up about 18 weekends a year.

Until 1965, it was generally accepted that casualties should be treated in hospital because outside treatment presented all sorts of difficulties, but little by little (with much pushing from Dr Nancekievill) on-site resuscitation has become accepted. St John's Ambulance have always played a large part, and continue to do so, but their role is supplementary to that of the motor racing rescue unit. In 1968, the BRSCC introduced the first such unit; Ford presented a small transit van (a year later to be replaced by a larger one), and the brief of the rescue team was to arrive at the scene of an accident within three minutes. There was always an anaesthetist in the van (usually David Nancekievill) and soon after the start of this service treatment was standardised within the first three minutes: even treatment of cardiac arrest could be begun before there was any brain damage. At that time, the van harboured firefighting and cutting gear as well as medical equipment, but later these were installed in separate vans. The medical supplies included a miniature ventilator, oxygen, Entonox, transfusion equipment, splints, and so on.

Britain led the world with this first rescue unit, and other countries learnt from us and followed suit later on. The unit was used primarily by BRSCC at Brands Hatch but was invited to the British Grand Prix, and later to Sweden, France, Austria, and Belgium (and with it, apart from Sweden, went David Nancekievill). The great gulf between the time of accident and arrival in hospital was bridged at last. The rescue unit saved many lives by treating drivers early—intravenous infusions were put up with them still in their cars, and they were often stopped from going into shock—or got out of it quickly—before the ambulance took them to hospital. David Nancekievill knows many of the drivers personally, but manages to retain his detachment when he treats them.

On-site resuscitation has gone from strength to strength: nowadays there are usually 10 doctors or more strategically placed at any international meeting at Brands Hatch, and something like 25 round the circuit at the Grand Prix. This means that a doctor can often reach a crash within 30 seconds; they are backed up by a Volkswagen Golf car with up-to-date medical equipment—oscilloscope, defibrillator, full transfusion equipment, intravenous cannulae, pneumatic splints, cervical collars, scoop stretchers (which will fit into any ambulance), and so on. Everything has to be small, simple, portable, weatherproof, and robust—accidents are a frightening sight and even doctors are shaky when they've seen a pile-up just in front of them. Dr Nancekievill says that at the racetrack, where accidents are plentiful (because motor racing is a competitive sport), there are few injuries, whereas on the motorway, where there are fewer accidents, injuries are frequent and often more serious. This he attributes to the drivers of racing cars wearing crash helmets, flame-resistant overalls (the doctors wear them too), good safety harness (David Nancekievill is most insistent that seat-belt wearing saves people in cars from serious accidents), as well as to sturdily-framed cars with anti-roll bars. Only in Formula One races are the accidents likely to be very serious. Even so, David Nancekievill has seen over 1000 accidents in his time, in half of which the driver wasn't injured at all; 150 of the remaining 500 went to hospital, of whom only three died. He has seen only one fatality on the circuit, but two others have been brought back to life by the rescue unit.

Despite this success story, which must be largely due to treatment on the spot, some clubs in Britain run their motor races with the minimum requirements of the Royal Automobile Club—that is, one doctor for the practice, and two for the actual race. Dr Nancekievill thinks this is totally inadequate. His ambition is to see the highest British standards adopted at all big international motor meetings around the world, so that the drivers can rely on the best treatment available wherever they may be—and, if he has anything to do with it, his ambition should be realised before too long. The injuries encountered on the racetrack are roughly a third to the head, a third to bones,

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and a third where there is no obvious injury but the accident has been so bad that the drivers are sent to hospital for observation and tests.

Another ambition that David Nancekievill has had for years —now, he says, unlikely to be realised—is to be medical officer on an offshore lifeboat. He has, however, been drawn into rescuing casualties in power-boat accidents. Like the motor racing, this happened accidentally: he bought a power boat for water skiing and was told that his best chance of being accepted as a member of the Chase Water Power Boat Club was to volunteer as medical officer. This he did, and now much enjoys this aspect of his leisure. The club has adopted a marvellous British invention—the first of its kind in the world—in the shape of a 17 ft Dell Quay Dory boat, which is unsinkable, and has a dropdown front (like a tank-landing craft) which enables the boat to be flooded to a depth of 6 inches or 1 foot so that casualties may be floated on board without having to be dragged over the side. When the flap is raised the water is automatically pumped out. The injuries are much the same as those in motor racing, with the added hazard of water, and the crew of the boat consists of one doctor (expert in resuscitation), two divers, and the driver.

David Nancekievill's alternative occupation is something of a busman's holiday, and not exactly what he set out to do in the first place, but it provides him with excitement and a chance to watch motor and power-boat racing, and he obviously very much enjoys the challenge of on-site medicine. He has found this work helpful in his everyday work—and his work in intensive care has helped him in his rescue work—and particularly so when he was senior anaesthetist at the Moorgate tube-train disaster a few years ago. He was in the train in the tunnel most of the day, and found his on-site medical experience invaluable. No one who has met him can doubt that his drive and enthusiasm have had much to do with the present excellent rescue services available in Britain —and he has lured many other doctors away from their gardens to help out. The drivers have much to thank him for.

Letter from . . . Chicago

Psychiatrists in restraints

GEORGE DUNEA

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This year, as a result of a rare unanimity of purpose among Jacobin and Girondin legislators, Illinois received a new mental health code, widely acclaimed by enthusiasts as the best thing that ever happened to psychiatry since Philippe Pinel freed the inmates of the Salpêtrière of their chains. Based on the premise that extreme illnesses require desperate remedies, the code represents the work of a host of liberals, lawyers, and legislators, who laboured for three years at a cost of half a million dollars to write down in ponderous legal jargon an attorney's perception of when and how a doctor may be allowed to treat a mentally ill patient.

In this enlightened and progressive code there are no doctors but only providers; no patients but only recipients of services; no hospitals but only facilities. Also, nothing can be done to a patient unless there is a presumption of potentially serious harm in the immediate future; and then only with written approval, written warnings, written notifications and reviews, and a whole rigmarole of legal mumbo-jumbo—giving rise to fears that untreated mentally ill patients will roam the streets in droves, rejected by the private sector and unable to be cared for by an already overburdened state system, using their newly found freedom to refuse treatment, to commit suicide, or to kill their neighbours in response to messages from Mars, because the lawyers had failed to see a difference between imprisonment in a prison and involuntary admission to a mental hospital.

The code heavily emphasises the rights of mentally ill patients, who must not be discriminated against and must not be deprived of their legal rights to marry, vote, manage their affairs, use their property, spend their money as they please, and work for wages. They cannot be presumed incompetent unless so determined by a court in a judicial proceeding separate from that determining the need for commitment. They shall receive adequate and humane treatment in the least restrictive environment; and shall be allowed unlimited opportunities to write letters, receive visitors, use the telephone, and avail themselves of forms of treatment relying exclusively on prayer. They may refuse drugs, electroconvulsive therapy, or other treatments (unless to prevent immediate serious harm to themselves or others); and no treatment may be initiated without prior written consent, formally witnessed and extensively documented.

Restraints and seclusion

The code addresses itself in great detail to the use of restraints and also of seclusion and isolation. Physical restraints are to be used in a humane and therapeutic manner, only on the written prescription of a doctor and only if there is a likelihood of the patient causing physical harm to himself or others. Restraints must not be put on too tightly, and they must be taken off when the patient wants to eat or use the bathroom unless, again, such "freedom of action may result in physical harm to the recipient or others." All orders must be written and documented, and no order shall be valid for more than 12 hours, when the doctor must again examine the patient (apparently even at 4 am) and renew the order in writing, as well as notify the facility director of his decision. The facility

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