Practice Research

The course organiser

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In 1965 one of us sent a questionnaire to all 142 trainee general practitioners in England and Wales.¹ In 1980 we made a survey of all 175 course organisers in England and Wales who are now arranging courses for over 2000 trainees—such has been the growth of vocational training for general practice over the past 15 years. Course organisers have been in existence since the early 1970s and are paid at the same rate as are trainers in general practice but cannot be paid in addition for having a trainee in their practice. They are appointed by the regional general practice advisory subcommittees of university regional postgraduate committees. Their main function is to run half-day or whole-day release courses that are attended usually weekly during university terms by trainees. Some also select trainers and trainees, organise trainer workshops, and assess training. At a conference in 1980, attended by almost half of the course organisers in Britain, it became clear that course organisers in each of the 15 regions in England and Wales perform many different functions, and we decided to survey all course organisers to find out their patterns of work and their opinions.

Methods

Two questionnaires were devised. One elicited opinions and no course organiser or region could be identified; the other elicited facts about the course organiser's job and the basis of this paper. The questionnaire was divided into the following sections: trainer selection and workshops, hospital posts in schemes, release courses, assessment, representation, and personal details about the course organiser. The questionnaires were posted to all course organisers in England and Wales in October 1980. One reminder was sent later.

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to those who had not replied. When there is more than one course organiser at a scheme only one questionnaire was requested from that scheme.

Results

One hundred and twenty questionnaires were returned (69%). All regions were represented. The number of course organisers in each region varies from six in Mersey to 17 each in Trent and in South-east Thames. The response rate varied from 33% in Mersey to over 90% in four regions. The proportion of trainees to each course organiser is very variable both in regions and between regions: there are six trainees per course organiser in South-east Thames and at the other extreme 31 trainees per course organiser in Wessex (though some course organisers in this region are designated associate organisers). The mean national ratio overall is 15.1 trainees per course organiser. The number of trainers associated with each scheme is variable. Figures from the Council for Postgraduate Medical Education returns in October 1980 show that the Northern and Oxford regions have proportionately more course organisers to trainers than other regions; East Anglia, Wessex, and the North-west have more trainers per course organiser than the average. Two-thirds (80%) of the respondents work alone, 20 work with one other course organiser, seven with two other course organisers, and 13 with "others," including lecturers in departments of general practice. At least three are designated as "regional" course organisers, as opposed to having prime responsibility to a district or area scheme.

TRAINERS

The relationship between the course organisers and the trainers is not always easy. Although both trainers and course organisers are paid the same, it is perhaps easy to see why trainers defer in opinions about training to their local course organisers, and it is easy to see how he may be placed in an authoritarian role. We asked what percentage of the trainers in each scheme had passed the MRCPG (member of the Royal College of General Practitioners) examination. There was wide regional variation: all the course organisers in the

organisers thought that their work occupied more than the two sessions for which they were paid. This is not surprising when the extent of their work is examined: organising and attending a half-day release course for an average of 15 trainees, running meetings for trainers, assessing trainees, inspecting training practices, arranging hospital posts, and attending many committees and regional meetings, to say nothing of trying to sort out the personal problems of trainees and sometimes trainers. Of course, not all course organisers are concerned in all these aspects of general practice training but many are, especially those in areas that are remote from the university centre of a region.

Many questions need to be answered about training for general practice. Is there an advantage in the trainee being in general practice being split into two halves or in being extended? If so, is there an advantage in it being spent in two or more different teaching practices? Is it important to have the release course attended by trainees throughout their hospital and practice training rather than just in their trainee year? Is a half-day release course adequate? Or should it be a whole day? Assessment of what we are doing in general practice education is essential if we are to improve our methods. Yet only 60% of schemes assess trainee performance, and most of this is not standardised in the region. We are not advocating that all schemes should be identical, but because of variation that exists without assessment no one will be helped to improve their own scheme.

We recommend greater conformity in representation. It seems absurd that the regional committee for general practice vocational training does not include a course organiser from each scheme in its region. The absence of a local scheme committee in about half the schemes seems to us to put too much responsibility for training on the shoulders of the course organiser: the whole responsibility for general practice training in a district should not rest with or be controlled by one or two individuals. They may well be the most knowledgeable about

education, but they need the active support of local general practitioners to do their job effectively.

Course organisers are at the centre of general practice training. Fifty-four per cent of them have not been given a job description. Many are not represented on regional education committees, and they receive the same payment as a trainer, who has the advantage of an extra pair of hands in the practice. It is not surprising that in many regions it is difficult to recruit new course organisers.

Conclusions

A postal survey of course organisers in England and Wales has shown that wide regional differences exist in their facilities and duties. Some have very wide responsibilities and must spend considerably more time on them than their nominal two sessions. It seems to us that improving the representation of course organisers on regional committees is likely to enable course organisers to improve training facilities in their region, and providing a democratic scheme committee is likely to be a useful support.

We thank our fellow course organisers for completing the questionnaires and Mr A O Hughes, senior lecturer in medical statistics, Department of Community Health, University of Bristol, for his help with the analyses. Dr M B Lennard gave considerable help in the preparation of this report, and financial support was provided by the Scientific Foundation, Royal College of General Practitioners.

Reference

¹ Whitfield MJ. Training for general practice: result of a survey into the general practitioner trainee scheme. *Br Med J* 1966;3:663-7.

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ONE HUNDRED YEARS AGO The London College of Surgeons appears now to have determined upon a step, into which it would be right to inquire too curiously as to the motives, but which is on the face of it for the public good, while by those who look below the surface it will, we believe, be seen to have an exactly opposite effect. The College proposes to increase and extend its medical examinations, with the ostensible view of remedying the present anomalous state of things, which allows a member of the College of Surgeons to go on the *Register* and to practice both medicine and surgery with impunity, without a registered medical man. There can be no doubt of the anomaly, and, indeed, it is one which we first dwelt upon, and in respect to which for a short series of years we published numerous lists indicating the extent of the anomaly and the danger; but we by no means admit that this is the right way of remedying it, nor can we accept the view that in this case a defective remedy is better than none at all. That no one should be registered as a medical man who has not been tested thoroughly in medicine and midwifery as well as in surgery, is now a truism, but it is far from being equally apparent that it is therefore right that the College of Surgeons—a purely surgical body, whose examinations have only a surgical value, and have no other legal status—should assume to itself the power, the duty, and the responsibility of becoming an examining body in surgery, medicine, and obstetrics. It is certain that, outside of surgery, the College of Surgeons, ruled by a body of pure hospital surgeons, will always be the worst examining body in the kingdom, just as in surgery it will always remain the best; and the marriage of defective examinations in medicine and obstetrics to complete examination in surgery is not what is required to bring about a sound state of medical education and registration. Any patching-up of this sort may be in the interest of the College, by giving an aspect of completeness to its diplomas, which no doubt the Council is right to consider; but it certainly is not in the interest either of medical education or of medical examination. It is not for us to suggest that they should be called upon in this way to go through multiple examinations by medical bodies in surgery

and medicine, and by surgical bodies in medicine and surgery before they can acquire a qualification to practise. Nor is it right to the public that the College of Surgeons should set up an inferior standard in one set of subjects, in order to justify and enhance its power and position of examining in others. It is equally mischievous, as impeding the progress of early and complete remedial measures in dealing with medical education and registration. It is much better fairly to face a difficulty, and openly to admit it, and to call for a remedy, than it is to apply a very imperfect measure, which is in itself an evil rather than a good. If the Council of the College of Surgeons were to go boldly and honestly to the Lord-President of the Privy Council, and inform him that they were in a difficulty as to their examinations, because the surgical examinations gave a right of registration, and therefore to practice—and to urge upon the Privy Council the necessity of taking steps to relieve them of that difficulty, and, if, meantime, they were to combine with medical bodies, such as the College of Physicians, to give a conjoint degree, and not to give their own diploma under any other circumstances, they might claim to be acting in the public interest; and there is no doubt that their action would have a beneficial influence in determining early legislation. Their present step we regard as retrogressive and selfish; although, possibly, the application of such a description may surprise those who are the authors of it, and whose intentions may fairly be considered to be of quite an opposite kind. It is necessary, however, to look behind the interest of corporations in this matter; and it is precisely because each corporation is still at the present moment fighting for its own hand, and working for its own interest in the name of the profession, that we once more earnestly protest against the present impotency of the Medical Council to regulate the actions of the corporations, and against the present resolute deadlock brought about by the unwillingness of the corporations, in the Medical Council, of the profession, whose interests are outside and above those of the corporations.

(British Medical Journal, 1981.)

Northern region, and most of the Oxford course organisers reported that more than 60% of the trainees have the MRCPG, whereas all of the Welsh course organisers and those in South-east Thames stated that less than 40% of their trainees had the MRCPG. In fact, 41% of course organisers said that their schemes had less than 40% with the MRCPG.

Attendance at workshops for trainers was considered to be better than 60% by the majority (75%), but at least five schemes still do not have workshops. In about half the schemes in South-west Thames and in the West Midlands the course organisers estimated that they are responsible for more than 40% of the workshop programme for trainers. In the remainder the trainers are given, or take, more responsibility. Sixty-four per cent of the schemes offer an introductory course in general practice to three-year trainees before they start their hospital posts. Thirty-one per cent divide the trainee year into two six-month periods not necessarily spent in the same practice; 53% have a continuous year in the practice; the remainder divide the year in other ways.

Hospital posts

A few course organisers are not concerned with hospital trainees but do co-ordinate the two years of hospital training. The selection of jobs offered to trainees varies considerably, depending on the availability and suitability of posts and on the attitudes of consultants to training for general practice. It is generally accepted that training in general medicine, paediatrics, obstetrics and gynaecology, accident and emergency, and psychiatry are the most suitable specialty training posts for aspiring general practitioners. There are few rotations without at least one in the Northern region and all the schemes in some regions, however, do not have a medical or paediatric job in their rotations. Sixty-eight per cent of schemes offer a specific package of jobs; 29% allow the successful trainees to apply for their own choice of posts from the available pool.

Release course

Nineteen per cent of release courses are full day and the remainder half day. Many of the full-day courses are regional courses. Ninety-five per cent of course organisers have their own release course, and the remainder share with other schemes. Most of the courses in South-west Thames, Oxford, Wessex, Mersey, and the North-west are designed for the trainees in their general practice year. Attendance by trainees in their practice year is in the main good; 64% of course organisers claim more than 80% attendance, and only 6% report it to be under 60%. Attendance by the trainees in their hospital posts is not so good, in part because some posts do not give release time or release courses are not available, and because it is often difficult for junior hospital doctors to have busy jobs, especially if there is limited cover. Ten per cent of schemes do not see their hospital trainees at all, and 19% have less than 60% attendance. Twenty per cent claim to organise different courses for hospital and general practice trainees.

The amount of the programme decided on by the course organiser varies. The regions where the course organiser decides on more than 60% of the programme in more than half of the schemes are Yorkshire, North-west Thames, West Midlands, North West, and Wales. No course organiser claims to do this in the Northern region and only one each in Trent, East Anglia, South-west Thames, and Wessex. Trainees have at least 40% say in at least half the schemes in the Northern, Trent, South-east Thames, South-west Thames, Wessex, and West.

We asked specifically about the content of the programme for the autumn term in 1980 and found that there were no consultant lectures in about half the schemes in the Northern, Yorkshire, Trent, and Oxford schemes. This does not mean, of course, that consultants did not contribute to the courses; they may have acted as resources during group discussion.

Facilities generally are good with 69% of courses meeting in postgraduate centres. Most schemes have access to basic equipment such as slide and overhead projectors, and most now own or have access to their own video cameras for recording consultations and role play. None of the schemes in North-east Thames, however, had a video camera, whereas all in the Northern and East Anglian regions have their own camera or share one.

Secretarial help varies. Most schemes have fewer than 10 hours of

secretarial assistance a week, but some, especially in the South-west Thames and Northern regions, have more than 20 hours a week.

Assessment

Thirty-eight per cent of schemes do not assess trainees' performance, and only 29% of trainee assessments are standardised in the region. The latter figure is unfortunately suspect, as there is considerable difference of opinion among course organisers in some regions about whether there is standardisation or not. It may be that assessments are organised by regional advisers and are unusual in the region that this is happening. There was no regional standardisation mentioned in Yorkshire, North-west Thames, North-east Thames, South-east Thames, and Mersey. There was rare use of assessment or perhaps not surprising as our methods of assessment of trainee performance are somewhat rudimentary. The Byrne-Freeman questionnaire has been used for several years, but only 21% of schemes (mainly in the Northern region and in Trent) use it to assess hospital trainees and 32% of schemes use it to assess general practice trainees. Only 35% of course organisers say that their trainees submit assessments of hospital posts; 69% submit assessments of their training practices and 67% of their trainers.

Representation

Local scheme committees exist in 45% of schemes; the remainder of schemes are run by course organisers alone or with regional advisers. There does not appear to be much overall agreement on this, as only the Trent, Wessex, and South-west regions have committees running most of their schemes. Of the schemes that do have committees, trainers are represented in 94%; trainees in 76%; local clinical tutors in 88%; the local faculty of the Royal College of General Practitioners in 63%; the local medical committee in 46%; and the British Medical Association in 17%.

Fifty-five per cent of the course organisers are not members of their regional general practice advisory committee. In some regions, notably South-east Thames and South-west Thames, no course organiser is a member of this committee. Sixty-eight per cent are members of their local postgraduate education committee.

Regional meetings of trainers, trainers, and course organisers are common, but 28% of schemes do not have regional meetings for trainers; 10% do not have such meetings for trainers; and 15% of the course organisers do not meet regionally.

Course organisers

Of the 120 course organisers replying, only four were women. Twenty-three per cent are less than 40 years of age, 42% are in their 40s, and 34% are over 50. They are usually members of three- or four-person partnerships, and 47% have two other trainers in the partnership. Sixty-six per cent have one trainee in the practice and 16% more than one trainee; 18% did not have a trainee in their practice at the time of the questionnaire.

Sixty-two per cent of the course organisers have not done a trainee year themselves, and 35% have not passed the MRCPG examination. Some have other educational or committee jobs related to general practice: 23 are members of the local medical committee, 17 are members of the district medical committee, 40 are members of other educational jobs, such as lecturers in general practice or Royal College of General Practitioner tutor.

The number of years that course organisers have been principals in general practice varied from a regional mean of 9.0 years in Mersey and 10.2 in East Anglia to 21.0 in the Northern region and 20.2 in North-east Thames. So course organisers had not been trainers before their appointment as course organiser: the longest time in a region that a course organiser had been a trainee was 1.0 years in West Midlands; the highest mean times were 7.5 in North-east Thames and 7.4 in Wessex. Surprisingly, perhaps, 54% had not been given a job description before or at appointment.

Discussion

From the opinion questionnaire circulated at the same time as the questionnaire described, we found that 70% of course

Law and the General Practitioner

Drunken driving

STUART CARNE

The offence of drunken driving is covered by the 1972 Road Traffic Act. The relevant sections are V and VI and their medico-legal implications differ.

Section V

Section V of the 1972 Road Traffic Act makes it an offence to drive or be in charge of a motor vehicle—that is, be at the driving wheel of a car, or elsewhere in the car if one else is in it, and in possession of the controls—while under the influence of alcohol or drugs. This is a *criminal* assessment. The blood alcohol concentration may be below 80 mg/100 ml: some are affected by a concentration as low as 30 mg/100 ml and in many countries the statutory limit is below 80 mg/100 ml.

The police do not have to ask the driver to take a breathalyzer test before arresting him under this section: it is enough for the officer to be of the opinion that the man's driving was impaired. Under this section it is obligatory that a request is made for a medical examination, and an appointed police surgeon will be called to carry this out. Should a police surgeon not be available, another doctor may be asked by the police. The driver does have the option of having a doctor of his own choice carry out the examination or be present: usually his own general practitioner, but I have been amazed at the selection of specialists sometimes requested, including gynaecologists, dermatologists, and venereologists.

I make it a policy when I see a driver arrested under section V to personally offer him the three options: to be examined by me, to be examined by a doctor of his own choice, or to refuse to be examined. Refusal to be examined under this section of the Act is not an offence. Nor is it obligatory under this section for the driver to provide a sample of blood or urine. (Alas, many drivers brought to a police station are drunk because the difference between the two charges, even if they knew beforehand, is small.)

There is no legal or even moral obligation for a doctor to stand the police station and wait for a breathalyzer test. Indeed, attendance might be to the patient's disadvantage if he is very drunk (and this is often the case).

The usual books to which lawyers refer as the authorities on the subject are: *The Drinking Driver*,¹ *Alcohol, Drugs and Driving*,² and *The New Police Surgeon*.³ Any doctor who is to give evidence in court in connection with a drink and driving case is advised to read these books before going into the witness box.

The driver's own doctor will be permitted to carry out an examination only in the presence of the police surgeon. If he arrives before the police surgeon he will have to wait. Often the

driver's doctor will ask the police surgeon to carry out the examination provided all the relevant findings are pointed out to him and he can, if he wishes, confirm these himself. The police surgeon will have to give his opinion to both the driver and the police. There is no obligation on the driver's doctor to say anything to anyone except the driver (or his solicitor). He may be asked by the police if he wants to record anything in his report book; there is no obligation for him to do so. The two doctors may, if they wish, confer together, and the driver's doctor may have a word in private with his patient (but the driver must be present). The police surgeon's report must be based on examination conducted in the presence of the police doctor.

EXAMINATION

The purpose of the clinical examination is to determine the following:

- is the driver under the influence of alcohol, drugs, or both?
- does he suffer from any other disease; in particular, a disease which could cause any or all of the abnormal findings?
- is he fit to drive (or be in charge of) a motor vehicle?
- is he fit to be detained in a police station?

When completing his report in the police surgeon's report book (book B3A) the doctor will be expected to state whether he found any evidence of disease or injury that might account for any abnormal behaviour; whether he found evidence of alcohol or drugs having recently been taken; and whether in his opinion during the period of examination the ability of the driver to drive a motor vehicle properly was or was not impaired through alcohol, drugs, or both. As an alternative to the last statement, the examining doctor might be prepared to say that he found insufficient evidence to say that the driver was able to drive a motor vehicle was impaired because of alcohol or drugs. (This last option is frequently misunderstood by lawyers: the doctor has not said that the motorist must be assumed to have been fit to drive. His opinion is akin to that of the physician who suspects anaemia but who awaits confirmatory evidence of haematology investigations.)

A relevant history should be obtained (and both the questions and answers recorded in the notes). When drugs are being taken in what dose, how often, and when was the last dose? In particular obtain details of any drug with a possible tranquillising action (including antihistamines). Did the patient have a reasonable night's sleep the night before, or has he been "moonlighting" and thus sleep from natural causes? Check if there is any history of diabetes or epilepsy. (Whether an epileptic should be driven is not the direct concern of the doctor carrying out this examination; but the history should be recorded and, if necessary, presented as evidence in court.) When was the last meal eaten? When and what quantity of alcohol does the driver say he has drunk in the last 24 hours? (Record the answers, if possible verbatim, however improbable they may be.)

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While taking the history listen for any slurring of speech and note the presence of any accent which the defence lawyer might, in court, suggest had been confused with slurring. Observe the driver's dress—for example—are the trousers flies undone?—is there any vomit (and does it smell of alcohol)?—is there any blood (suggestive of recent injury)?—are the underclothes soiled with urine or faeces? Note his demeanour. Record any physical disabilities. The failure to observe a glass eye is an obvious error; the failure to remember that dentures were worn could be used to suggest that the mouth was not properly examined. Keep a note of all operations and other scars be prepared to comment in court on whether a previous meniscectomy could affect knee jerks.

A smell of alcohol on the breath indicates only that some alcohol has been consumed, but it is only a teaspoonful. The most important findings in the eyes are dilated pupils that react only a little—or not at all—to a bright light and the presence of nystagmus: both findings may also be found in patients who are under the influence of tranquilisers, especially barbiturates. Though bloodshot eyes are often seen in those who have consumed alcohol, the finding is too non-specific to be of diagnostic value. The ears should be examined to exclude an aural cause for nystagmus.

In my opinion heart rate and blood pressure are of little importance in assessing the effect of alcohol—though both should be recorded. The anxiety of being arrested could cause both to go up. (Pulse irregularities or a blood pressure outside the normal range may be relevant in the other medical contexts.) A full bladder is a not uncommon finding, especially in men drinkers. A large liver suggests chronic alcoholism but not acute intoxication. The reflexes, including the plantar responses, are often absent on both sides in those who are under the influence of alcohol; unilateral changes, however, suggest some other disease.

The most important tests are those for co-ordination; slurring of the speech and the presence of nystagmus may be enough to enable the doctor to form the opinion that the defendant is unfit to drive. Getting the driver to write his name and address on a sheet of paper and perhaps also copy out a sentence from a book or form is useful additional evidence, but be sure to retain the paper with his writing. Other tests, such as walking a straight line and the finger-to-nose test, are not always understood by a lay jury and may only confuse the issue if they are the sole evidence on which the opinion is based.

Section VI

Under section VI of the 1972 Road Traffic Act it is an offence to drive a motor vehicle with a blood alcohol concentration greater than 80 mg/100 ml (or a urine alcohol concentration greater than 107 mg/100 ml, which is the equivalent). The police have the right to request a driver to provide a sample for analysis if he fails the breathalyser (or if he refuses to take that test). Two breath tests are given: the first at the roadside and the second at least 20 minutes later, usually in the police station. Both must be positive. If the driver decides to give a urine sample then he must provide two specimens within one hour of agreeing to give the sample. The first is discarded; an analysis is made of the second. A doctor is not required to assist in this procedure.

If a blood sample is offered this must be taken by a doctor, usually an appointed police surgeon. A driver may request that his own doctor take the blood. This is possible (under section VI) only if that doctor is available at the station when the sample is wanted or can arrive before the police surgeon. No delay to allow time for his own doctor to arrive is permitted. Before the blood can be taken the driver must give permission to the doctor for the procedure to be carried out. A statement by a police officer that this permission has already been given is not sufficient: it must be confirmed by the doctor collecting the sample.

Although no medical examination is required when section VI procedure is being followed, it would be prudent to ask the driver if he has any illnesses or injuries and whether he is taking any medication. If necessary, he may then—with his permission—be examined as usual. In most cases there are no other medical problems and no clinical examination is needed. All the doctor has to do is collect the sample of blood.

BLOOD SAMPLE

Two to 3 ml of blood should be taken (if necessary, less will suffice). If the skin is to be cleaned—some would argue that for ordinary clean skin this is unnecessary—only swabs approved for the purpose may be used. These swabs should be available at the police station. The usual medical swabs contain alcohol and must not be used. The sample is divided roughly equally into two special containers provided by the police. They have rubber caps that seal the blood sample in the bottle, and the bottle itself is sealed in an outer container that cannot be opened without breaking the seal (thus preventing interference with the sample). The driver is invited to select one of the samples and his sample is further sealed in an envelope over which the driver and the police officer sign their names. A sample which has in any way been tampered with cannot be accepted by an approved laboratory for analysis of blood (or urine) alcohol content.

Few hospital laboratories have the equipment to carry out blood or urine alcohol analysis. The Royal Society of Chemistry have produced a list of laboratories which will perform this task (the cost is approximately £25) and the driver should be given such a list when he is handed his sample by the police. Should he subsequently bring the sample to his doctor to get it analysed, this list can be obtained from any police station. In practice, although there is rarely any important difference between the findings of the police forensic laboratory and those of an independent laboratory, the second analysis is an added safeguard for the motorist. Another advantage is that he will get a result much quicker: the police laboratory may take up to three to four weeks to produce its findings.

References

1. *The drinking driver*. London: British Medical Association, 1965.
2. *Alcohol, drugs and driving*. Supplement to *The drinking driver*. London: British Medical Association, 1974.
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Searching for a practice

Once I went for an interview in a practice that consisted of an uncle, his nephew, and another man. They wanted another young partner. The system would be that we would do one weekend in four, but they did it by the calendar month and if there was a fifth weekend in the month then you would always do the fifth weekend. You would also—as the junior—be responsible for obstetrics with the other junior, the two seniors did no obstetrics. But although you were responsible for the obstetrics you wouldn't receive the money; it would be shared out according to the practice shares, and you got a pitiful share. Also, supposedly it was very tiring and of one of the patients went into labour, but that weekend you would be on duty for her throughout the weekend because the seniors couldn't possibly do anything like that. I liked the nephew, but he was obviously being grossly exploited by his uncle. He'd have loved me to join the practice so we could fight the senior together, but I didn't—KEN DICKINSON, general practitioner, Birmingham.

We will be pleased to consider similar interesting stories about general practice.—Ed, BMJ.

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Unemployment in My Practice

Rotherham

M HAMID HUSAIN

General practice recently has been somewhat trying for some of us in South Yorkshire. The area of 1970-80 was dominated by the steel strike, heralding an atmosphere of doom and depression in the area, which left its mark for months to follow. Summer was there, only name, with hardly any sunshine during the gloom and despondency. True, there were no major epidemics to test our reserves, but the frequent spells of bad weather from the autumn, which lasted to Easter this year, with the almost inevitable virus infections and an escalating level of unemployment in the area—with its own problems—tired our stamina and put under scrutiny our skills as caring practitioners.

This has been a period more demanding than most for me in my average single-handed practice, in a suburban area far from deprived where the patients belong to all socioeconomic groups and where the housing is generally of good standard. It has brought droves of anxious, worried, and insecure people into the surgery, seeking not just prescriptions for linnetes for coughs that tended to linger more than usual, analgesics for the pain that seemed to hurt more than usual, and antibiotics for infections that they believed more lethal than at any other time, but also looking for reassurance, help, and advice.

Yorkshire people are always proud, usually self-reliant, pragmatic, even if blunt and open, and are seldom given to flights of fantasy (unless, of course, cricket was uppermost in their minds). Nobody expects them to come into the surgery, open their hearts out, and grumble about the problems facing them. And they never did, preferring instead to keep their chin up in most ailments. In the country, the "upside down" was their difficulty, even when they looked unimpaired, with their utmost stoicism. All the same, the signs of strain were there for those who had eyes to see the anguish on their faces and ears sensitive enough to appreciate the change in the tone of a voice that spoke volumes. The waning sense of humour and the agitated repeated attempts to seek reassurance, when at other times none had been required, betrayed their self composure and revealed an inner sense of discomfiture that became more and more evident during a prolonged consultation, provided of course that one had the time or the patience to make it prolonged. Who indeed could blame them, with an unemployment rate in the area exceeding 15%, and thousands of young people registered with the local job centre looking for employment. In a town dependent heavily on steel, the possibility of the closure of British steel and other associated companies has been like the farmer being threatened with a total and lasting drought. When the pressures increased, depression set in, and the limbs began to ache they turned towards their GPs.

There was the grandmother who kept coming to the surgery with vague abdominal pains, unable to be convinced of the benign nature of her ailment, until I talked to her at length

about her son who she confessed was in danger of losing his job. One detailed consultation elicited her whole family history and embracing everyone's present and future job prospects was followed by her complete disappearance from the surgery, and she has never been seen in there since. I remember, too, the young housewife who seemed so concerned about her baby's non-existent rash until I realised it was my attention and counsel she was after and not any fanciful dermatological diagnosis. It soon became apparent that she had been distressed by her husband taking an overdose. Frustrated by the threatened redundancy, he had finally snapped. Words of comfort were all she was looking for. The extent to which people can identify themselves with the trials and tribulations of others is truly amazing. One fairly prosperous housewife, with two adorable children and a loving and generous husband, suddenly became full of symptoms and developed a phobia about cancer. It was only after repeated consultations that the real story emerged. Apparently she had been increasingly depressed after a friend of hers lost her job and subsequently developed cancer.

In my experience the fear of unemployment and the feeling of insecurity that this can bring is more responsible for mental stress and psychological trauma than unemployment itself. It is almost as if the pressure is released once the catastrophe has happened. A young man who had complained of a non-cardiac chest pain all the while that his firm's redundancy plans were being drawn had been conspicuously absent from the surgery ever since they were actually announced and he joined the long army of the unemployed. Life for the unemployed has been easy either. A conscientious manager I know developed early signs of alcoholism under the mental stress of planning and executing the redundancy arrangements. The thought of some of his long-standing associates losing their livelihood was more than he could face while in a sober state. Another young executive complained of impotence at the height of a stressful period at work, feeling certain, wrongly, that he was going to lose his job.

When people are under stress they react impatiently, impetuously, and irrationally to even simple problems. Couples known to be "as gentle as lambs" have recently argued and quarrelled fiercely, affecting their family and marital relationships. Expressions like "He/she is always chinning at me these days," have been heard noticeably more frequently.

I have very few immigrants in my practice, but my role as medical adviser to industry has brought me into contact with many Asians, who I believe have coped reasonably well in spite of being disproportionately affected by unemployment. Some quarrelled fiercely, affecting their family and marital relationships. Expressions like "He/she is always chinning at me these days," have been heard noticeably more frequently. I have very few immigrants in my practice, but my role as medical adviser to industry has brought me into contact with many Asians, who I believe have coped reasonably well in spite of being disproportionately affected by unemployment. Some quarrelled fiercely, affecting their family and marital relationships. Expressions like "He/she is always chinning at me these days," have been heard noticeably more frequently.

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The demoralising and destructive effect of unemployment on young people has disturbed me greatly. It is sad to see a well meaning and usually well adjusted youth from a secure home background lose a sense of purpose and direction. Some of them seem to be fast losing their self discipline as well. A young-looking 17 year old apologised to me for a late attendance at the surgery (at 10.30 am). "Sorry," he said, "I do not get up early these days, there is nothing to be done." One cheeky 16 year old was brought by his mother for a possible specialist referral after he had been in trouble with the authorities for petty pilferage from his school. He was brought by his mother because he thought there was nothing better for him to do. Boredom, disillusionment, and lack of faith in the future seem to be torturing their minds. A pretty, intelligent schoolgirl from a well-to-do family lost all interest in her food, studies, and life, and developed signs of anorexia. Her answers were not realising. "What is the point of studying when there is nothing at the end of it?" Life for her was an endless and purposeless routine. I hope she will find something to do.

How am I coping? I am afraid there is hardly anything one can do in these circumstances except listen. It is surprising

though how much that can achieve, provided one listens carefully and patiently. I wish only that I had more time. Although the parent/doctor consultation is often the only one available, the time for consultations have been more difficult and prolonged, I am certain my prescription frequency has not altered. Very few of the patients consulting me for their psychosomatic ailments, domestic problems, or marital difficulties, or employment worries have demanded, or even expected, sedatives or tranquilisers. These are simply people under stress in a social atmosphere of depression and recession, not knowing when or even if the situation will improve. Some of them have even apologised for taking up my time for trivial reasons, but come they did, not knowing what else they could or should do. It is the support and reassurance that they have been mainly after and when given they have been grateful for it. Many of them have made my job as a general practitioner worth while and given me more job satisfaction than they may have realised. How wrong was I in thinking until recently that my skills as a doctor were not being used. In these circumstances it is the doctor who is as much on trial as the patient. I feel sure they have passed their tests. But have I? Only they can answer.

Emergencies in the Home

Managing overdoses

K C HINES

The management of overdoses in the home begins with the telephone call requesting help. Has the caller taken the overdose, or is he telephoning on behalf of someone else? It is important to find out the state of mind of the patient, the nature of the overdose, and what has been taken (if known) and when. If the patient makes the call, it is useful to ask whether anyone else is in the home and, if not, to advise the patient to open the front door so that the visiting doctor or emergency ambulance crew can get in as the level of consciousness deteriorates. If a relative or friend is phoning, reassure the person and give simple first-aid advice about how to keep the airway open, and instruct the person not to make the patient vomit but simply to keep him company, talking quietly if he is conscious, laying him down in the recovery position if he becomes drowsy. (It is a great relief to be able to reassure an anxious mother that the toddler who has taken an overdose of her deliberate or accidental overdose of drugs or other poisons. Although an ambulance should be called the general practitioner should make an urgent visit if possible. He may then assess the home circumstances and the needs of the persons involved, and this will help considerably in the managing of the patient when he is discharged from hospital.)

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On arriving at the patient's home if the patient is co-operative ask what was taken, how many, and why. This information must be regarded as unreliable and should be used only as a guide. Relatives may either overstate or understate the risks because of anxiety or guilt. Any empty containers or tablets that are left should be collected together for the hospital casualty officer, but even this is of only limited value since few drugs have specific antidotes (apart from narcotics and iron).

Treatment

Emesis has almost no part to play in managing overdoses in the home. Saline and mustard emetics may be dangerous and should be avoided. Petroleum products, acids, and corrosives are safe left in the stomach; the risk of problems from inhalation is too great to attempt forced vomiting. Giving the patient milk to drink may be useful for diluting corrosive and petroleum substances. In the case of a child who is fully conscious, particularly if he has swallowed aspirin, ipecacuanha mixture may be effective (10 ml for a child aged 6-18 months; 15 ml for older children). Gastric lavage is also of doubtful value even in the casualty department, particularly if it is done more than four hours after ingestion; it may, however, be useful for overdoses of aspirin or tricyclic antidepressant drugs.

The immediate care of most patients who have taken overdoses is therefore purely supportive. Particular attention should be paid to respiratory function, hypotension, and cardiac arrhythmias. All comatose patients should be placed in a semiprone or recovery position, using pillows or cushions when appropriate. An appropriate-sized oropharyngeal airway should be inserted

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after clearing the airway of any vomit or debris. Most poisons that cause coma may also depress respiration, and assisted respiration should be given by an endotracheal tube, and these patients are often recognisable by venous tainting and pin-point pupils. They can be woken up with intravenous naloxone hydrochloride 400 µg, repeated if necessary two or three times, but they should still be kept under close observation. Occasionally I am called to see patients who have taken an overdose but are still fully conscious and refuse hospital treatment. If I can find a suitable adult or friend, I simply advise that person about first-aid management. The ambulance crew and I would then withdraw and would expect to be recalled later when the patient was too drowsy to comply.

Many overdoses are a cry for help, and a home visit is valuable in assessing the family dynamics, the conditions in which the family is living, and other relevant problems. A lot of support may be needed by the family as well as the patient to combat depression, guilt, and anger.

All general practitioners should carry the telephone number of the National Poisons Information Service nearest their practice. This service is especially helpful whenever unusual or exotic substances have been taken. Recently I sought their advice to identify a proprietary greyish-black cleaning fluid drunk by a small child.

Telephone numbers
Belfast 0232 30593
Cardiff 0222 49223
Dunblair 0911 74568
Edinburgh 011-229 2477
London 01-407 7600

Overdoses are the commonest medical cause of admission to hospital. There is much that can and should be done for the patient before he is taken to hospital. Doctors used to be taught that at all costs they should keep the patient awake by walking him up and down and slapping his face. This is pointless and may even be detrimental since it may increase metabolism and hence absorption. Once the patient has told someone what substance was taken, when, and perhaps why, he should be allowed to drift into unconsciousness, confident that the general practitioner will keep him safe and give him the best life-support treatment before the ambulance arrives to take him to hospital.

Common pitfalls

Patients who take aspirin overdoses rarely lose consciousness unless they have taken another drug as well. This may often fall people into a false sense of safety, but the ensuing metabolic imbalance may still be fatal. Patients who have taken an overdose of tricyclic antidepressants may lose consciousness. In Cases 1 and 2, I remember one such patient walking into the ambulance rapidly.

ONE HUNDRED YEARS AGO Sir,—About eight months ago, you were good enough to allow me to point out that, in cases of deaths from chloroform, it transpired in evidence that little of the drug was in fact in the stomach, but that it was absorbed into the blood stream. The patient was quickly placed under its full influence, where death took place during or after the anaesthetised state. I pointed out how unfair it was for a section of the profession to pour pure chloroform vapour into patients' lungs, and, in cases of death, attribute the death to the use of the drug.

Dr. Leitch then, in his speech, I now use his statistics to show him and the profession I was right. In every case he has recorded, direct evidence is given that chloroform vapour was poured into the patients' lungs from tin, funnel, or inhaler (under his table). In Cases No 32 and 38, no mention is made of how the towel and napkin were used, it is held over the face or not. It is not true that chloroform is a weak depressant? That the prospect of an operation is also a cardiac depressant? That, in ordinary stethoscopic examinations, patients often feel faint, and, for water, and, if standing, ask to sit down? Again: is the vapour of

chloroform heavier than air? Can air circulate as freely when a masked thing like tin, funnel, or even a lady's veil, is held over the face, as if no such impediment were there? Does the air breathed during chloroform administration require mixing with only a small percentage of chloroform vapour (5 per cent), or no more?

But, some say, patients die after they have come out of the chloroform. To this I reply, that such patients as much "come out" of the chloroform because they are seen to recover some of their senses, as the partridge, fatally struck with a shot, may be said to come out of it, because it is seen to fly as straight after the shot as before it for half a mile, then rise perpendicularly into the air ("toss," as sportsmen call it), and drop dead.

The first death from the administration of good respirable air, properly charged with chloroform vapour, has yet to happen; and I challenge Dr. Jacob, or any member of the profession, to record a well-authenticated case, when the vapour has been administered on rational principles, and the patient's heart and pulse have been at least once—I am, sir, yours truly, WILLIAM FARNLEY. (British Medical Journal, 1881.)