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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 well. 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.

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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, whatever it was you were on call for and if you patients went into labour, then 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, and antibiotics 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 County cricketers are 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. The only exception was when they had difficulties, even when they looked insurmountable, with their most 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 not 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 in by declaring that 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 the only one that is available, the time 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 general 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 the patient, the level of consciousness, 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 safer 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 but 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 Ambu-bag or other device, 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 breathing and given oxygen. 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 492233
Dublin 0011 745688
Edinburgh 011-229 2477
London 01-407 7660

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 breathing and give him basic 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 (do not take them on an empty stomach) may lose consciousness rapidly. I remember one such patient walking into the ambulance

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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 taken into the system, and that the patient was usually found with the vapour in his lungs, and in 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, in which 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, that is, held over the face or not. It is not true that such patients were given a cardiac depressant? That the prospect of an operation is also a cardiac depressant? That, in ordinary obstetric cases, 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), and 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 alone.—I am, Sir, yours truly, WILLIAM FEARNSLEY. (*British Medical Journal*, 1881.)