PRACTICE OBSERVED

Trainees' Conference Report

Hanging loose in Sheffield

SUE BURKHART

Maintaining their independence as a group and improving communication among trainees were the overriding concerns of the 200 vocational trainees who met at Sheffield University for the fifth National Conference for General Practice Trainees. The two-day meeting also clarified some of the difficulties that vocational trainees have during their two years of hospital training—such as the lack of obstetric posts. The conference heard the results of a questionnaire sent to hospital consultants and to trainees about hospital posts for trainees; discussed the present and future of vocational training; heard about the future of obstetrics in general practice; and debated the motion that adequate primary care cannot be provided until the number of GPs is at least doubled. The mood of the trainees at this conference was low key, unlike that at Exeter last year when a lot of the problems of vocational trainees were aired. Reason, confidence, and humour dominated the discussions, and this undoubtedly was not lost on the trainers, course organisers, regional advisers, and representatives of the Royal College of General Practitioners, the Joint Committee on Postgraduate Training for General Practice, the Department of Health, and the General Medical Services Committee who were there. The trainees conference was a valuable education for their seniors.

Consulting consultants and trainees

The conference organisers, Dr Ed Warren, Dr Diane White, and Dr Jeanette McGarrigle of Trent region were pleased with the 50% response from hospital consultants to their questionnaire about hospital posts held by trainees, whereas only 40% of trainees in a three-year structured scheme who were sent questionnaires responded. The consultants thought that trainees had more opportunities to take study leave and day-release courses than the trainees thought they had. This pin-

pointed the problems that trainees in busy hospital posts have in getting time off to attend day-release courses run locally by course organisers, and thus keeping in touch with the others in their training scheme. Trainees also thought that they got too little outpatient work and too little training in specialties, such as ENT, ophthalmology, and dermatology. Both trainees and consultants thought that consultants should help to select trainees for hospital posts and that it would be beneficial for the consultant to have some experience in general practice.

The benefit of experience

Small group discussions highlighted what the trainees thought about hospital jobs, obstetrics in general practice, the membership examination for the Royal College of General Practitioners (RCGP), and training for future general practitioners. The two years of hospital posts were valuable, although a few trainees thought that these should be oriented more to general practice and that more than one of the three years should be spent in general practice. Trainees should be able to take an approved, but not mandatory, obstetrics and gynaecology job for six months as a normal part of training. And more posts in obstetrics should be approved for trainees, as it is difficult to get them in some areas, and there are too many one-night-on-and-one-night-off obstetric jobs. The trainees who answered the questionnaire were mostly doing hospital posts with one night on and two nights off. Most of the trainees at the conference intended to practice intrapartum obstetrics—showing a commitment to continuous care and a definite change from what goes on now. Should there be a compulsory examination for GPs, perhaps at the end of training? The answer was: No. But some continuing assessment was acceptable. Trainees thought that they were pressured in to taking the MRCPGP (membership of the RCGP) at the end of their training. Examples of this were that the MRCPGP was used to assess candidates for jobs as principals in general practice; a trainee was asked if he had the MRCPGP when he interviewed for a training scheme; and one day-release course for trainees was oriented towards the examination (not

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the intended purpose of such courses). Most of the 300 trainees who were at Exeter last year intended to take the exam, and 69% of the trainees in Devon and Cornwall did not want a compulsory exam, but 74% intended to sit the MRCPGP exam. The exam was intended for college membership and not for entrance in to general practice. One suggestion was to delay the exam for five years after becoming a principal.

Though a few trainees complained privately that trainees had too much to say in some discussion groups (the trainees would have preferred to be a little idealistic without being told that such and such idea was old hat and had been tried years ago), this was not true in all groups. Trainees were articulate and sure of their ground when discussing how adequate training should be assured for future trainees. Changing the attitudes of teachers in medical schools, where the place was hospital medicine, was the place to begin. General practice was still held in low esteem in many medical schools. Keeping contact with general practice throughout the three-year scheme by attending day-release courses was important, as was forming strong regional trainee committees. Furthermore, trainees, trainers, and consultants should work together more. As one trainee said: GPs who make good referrals make for better relations between hospital medicine and general practice. Some training schemes were bad and to try to put things right the Joint Committee on Postgraduate Training for General Practice visited these schemes, but the visiting team should include a trainee.

Trainee policies

After the unrest at Exeter last year over the trainees' lack of representation and influence the General Medical Services

Committee set up a working party to suggest how to strengthen the representation of trainees nationally. The GMCSC's main task is to look after the terms and conditions of service and to consider education for general practitioners. The trainee sub-committee of the GMCSC is the only existing representative body for trainees, and most of the regional vocational training schemes send a representative. The working party's report, which was presented to the trainees at Sheffield, was a potentially positive step, but when the trainees felt that they were being pushed into accepting being organised by the GMCSC they demurred, objecting particularly to a clause that said the subcommittee should in future set up the national conferences, liaising with other bodies as necessary. The trainees thought that the working party was suggesting that the subcommittee take over the trainees' political power—which is as yet undefined and unharnessed. While agreeing that regional and local organisation badly needed to be improved, the conference disagreed with any idea of affiliating with established bodies such as the BMA and the RCGP, though wishing to retain ties with both. They will consider the recommendations again at next year's conference in Cambridge, which will be organised by a few trainees who volunteered. This will be followed in 1983 by a conference in Mersey. Such independence and enthusiasm belie all the talk in the conference about apathy being rife among trainees, whose numbers may exceed 4000 scattered throughout the Health Service.

By the way, where were the rest of you this year?

Reference

1 Anonymous. Gripes from Exeter. *Br Med J* 1980;281:369-70.

Emergencies in the Home

Managing paediatric emergencies

M J BROWNE

This article gives a brief outline of common paediatric emergencies that family doctors have to manage and offers a guide to how some of these crises may be resolved.

The doctor is usually contacted directly by the family and has to decide with only a little information whether practical advice given over the telephone will suffice or whether a visit is necessary. An analysis of mismanaged childhood illnesses leading to litigation showed that the commonest symptoms leading to error are those that are seen routinely in a busy family doctor's day—that is, diarrhoea and vomiting, abdominal pain, headache, convulsions, and stridor.

Children may become ill alarmingly rapidly, but fortunately many recover just as quickly. A few simple maxims, if observed, may help to reduce errors:

(1) If the parents are worried or unhappy with the advice given, however seemingly trivial the complaint, the child should be seen.

- (2) If in any doubt, see the child again or ask for help, either by admission to hospital or from a domiciliary consultation.
- (3) Do not leave all the responsibility to the child's parents; if there is any doubt, then arrange to visit again.
- (4) Admission to hospital may be necessary for both medical and social reasons.

Accidents

After the first year the commonest cause of death in children is trauma. Children have little awareness of the potential dangers outside or in the home.

HEAD INJURY

Children appear to fall and hit their heads regularly. Medical assessment is always necessary if there has been a period of unconsciousness or if the child behaves abnormally. These children are usually pale and may have vomited once. They need to be examined carefully and if there are no abnormal

neurological signs then they may be kept at home. The parents must be instructed to contact the doctor should repeated vomiting occur or the child's behaviour become abnormal. When the child has been unconscious for more than a few seconds or any abnormal clinical signs are present then hospital assessment is required.

ACCIDENTAL POISONING

Poisoning in children is common but fortunately rarely fatal. In 1977 16 children under the age of 10 years in the United Kingdom died from accidental poisoning, the commonest lethal poison being tricyclic antidepressants, with salicylates a close second. The introduction of child-resistant containers for all medicines will help to reduce this problem further. As soon as a child is able to crawl a range of chemicals is potentially available for ingestion. Obviously health education for parents is the main preventive approach to this problem.

When called to see a child who is thought to have swallowed a noxious substance, you should first establish exactly what and how much has been taken. The regional poisons centre gives prompt advice about the toxicity of most substances. Fortunately, most substances taken are non-toxic, and the child may safely be managed at home without any treatment. If the child is seen within two hours of ingesting a poisonous substance, then vomiting should be induced with ipecacuanha syrup. Ipecacuanha-induced vomiting is most effective if given within two hours of ingestion. The use of ipecacuanha is contraindicated only if petroleum products have been taken or if the child is drowsy. It is helpful to keep a specimen of vomit and the suspected poison for analysis. Salt-induced emesis is particularly dangerous and should not be advised.

Medical emergencies

FEVER

Much of a family doctor's contact with sick children is because of a febrile illness. Fortunately, most fevers are due to self-limiting viral illnesses, which require symptomatic treatment only. If the temperature is higher than 38°C and the child is examined, a source of infection is usually found in the ears, throat, or respiratory system. When no focus of infection is found the urine should be looked at and sent for bacteriological culture. Antibiotics should be prescribed if indicated, but practical advice to the parents as to how to control the temperature is probably of more immediate value. Soluble aspirin or paracetamol may be prescribed in adequate doses; the parents should be told how to tepid-sponge the child, and they should be warned not to overwrap.

The higher the child's temperature above 40°C the greater is the danger of fits and brain damage. As important as lowering the temperature is the need for adequate fluid intake, allowing for increased insensible losses. Any child with a temperature of 40.5°C should be admitted to hospital, as it is likely that the cause is a serious bacterial infection, such as meningitis or septicaemia.

ASTHMA

An acute wheezing attack is frightening for both the child and the parents. The family doctor's first function is to help to allay this panic. The doctor is usually called after the family has failed to stop the attack with the child's usual bronchodilator (oral or inhaled). An initial assessment should be made; a pale cyanosed child with a pulse rate greater than 160/minute and poor air entry requires urgent admission to hospital, but

treatment should be started at home: (a) oxygen, if available, should be given; (b) inhaled salbutamol through a nebuliser, or subcutaneous terbutaline 10 µg/kg; (c) if feasible, then 200 mg hydrocortisone may be given intravenously for more than a few minutes.

The child whose symptoms are not so severe requires the reassurance of firm management and the relief of the wheeze. Again, giving salbutamol via a nebuliser is excellent treatment, and subcutaneous terbutaline may give rapid relief of symptoms. It may also be necessary to start a short course of oral steroids.

CROUP AND STRIDOR

Croup or stridor is always frightening for both the doctor and the parents. The parents should be advised to place the child in a steam-filled room (easily obtained with a boiling electric kettle) before the doctor arrives. About 95% of cases are viral and will respond to this kind of management. The child that is restless and unable to feed, tachypnoeic with increasing respiratory effort, and has a tachycardia greater than 160/minute will need hospital admission.

In epiglottitis due to *Haemophilus influenzae* the history is of a rapidly worsening illness, with dysphagia and drooling, and a muffled rather than hoarse voice. If epiglottitis is suspected, then you should not attempt to examine the throat, and the child should be taken immediately to hospital in the doctor's car with the parents sitting the child upright. Oxygen should be given if available. It is worth carrying a wide-bore cannula such as a Medicut, which can provide an open airway should the airway become obstructed completely. A family doctor can expect to see only one case of epiglottitis in a lifetime but many children with croup. It is worth having a low threshold for visiting and revisiting those who are kept at home.

DIARRHOEA AND VOMITING

In children diarrhoea and vomiting are usually caused by a viral illness and should settle without any medical intervention. Giving advice over the telephone is all that is necessary in most cases—to stop all food for 24 hours and to give small quantities of cooled boiled water regularly. Dehydration is a major risk to children under 18 months of age. Antibiotics should never be prescribed, nor should diphenoxylate and atropine (Lomotil), or other antidiarrhoeal agents. If diarrhoea persists for longer than 24 hours it is worth using an electrolyte solution, such as Dioralyte, to help replace electrolyte losses. It is also beneficial, as the parents feel they can then contribute positively to the child's treatment. If the child is severely dehydrated (assessed by skin turgor, mucous membranes, fontanelle, and eyes) then admission to hospital should be arranged.

ABDOMINAL PAIN

Children are not good at localising abdominal pain, and if a child is screaming with pain careful assessment is required. On no account should such a child be sedated, as this may confuse the physical signs and delay the diagnosis. A full examination may show the cause of the distress—for example, an incarcerated inguinal hernia or torsion of the testis. A history of intermittent screaming and drawing the knees up and pallor suggests an intussusception.

FITS AND FAINTING

Episodic events, such as fits and fainting, in children are often difficult to sort out, but a careful history will often lead to the correct diagnosis. In cyanotic breath-holding attacks the

child is described as going red then blue, often appearing rigid, and the whole episode lasts a few seconds. Occasionally the child actually has fits as well. The history of temper or fright before the episode helps to suggest that the cause is a full explanation to the parents are all that is necessary. Convulsions in children under the age of 31 years are usually associated with high fever; it is, however, wise to admit children after a first convulsion unless you are absolutely certain there is no underlying intracranial infection, metabolic abnormality, or space-occupying lesion. The clinical signs of meningitis in a child under 2 years are unreliable. The parents should be advised over the telephone to remove the child from places of danger. Nothing should be put in the child's mouth, but he should be placed in the coma position to keep the airway open.

If the child is still having a fit when the doctor arrives diazepam 0.25 mg/kg should be given intravenously, or rectally, as this is also rapidly effective. A safe alternative to diazepam is paraldehyde given by deep intramuscular injection. The dose is 1 ml per year of age. A glass syringe is not necessary when the drug is given immediately after it has been drawn up.

In all cases of convulsion, febrile or otherwise, a Dextrostix test should be performed to exclude hypoglycaemia. Subsequent febrile convulsions may be managed at home as long as a focus of infection is recognised and appropriate treatment advised to prevent rapidly rising fever.

Clinical Curio: folk machine epilepsy

A 50-year-old man recently suffered a grand mal seizure while playing a "folk machine" at his golf club. He habitually played the machine standing tangentially to the (four) revolving discs, each of which revolves at a slightly different rate on a common axis and is halted asynchronously in a random manner. The discs are illuminated by a fluorescent tube sited behind the discs. Some years ago he had another grand mal seizure while in a situation of unusual light manipulation. This raises an unusual point. Should he be excluded from driving a motor vehicle until he has been seen by—ERIC TRIMMER, general practitioner, Loudwater, Hertfordshire.

Vintage years

In a remarkable cove in a country market town nestled in the heart of mid-Wales, still dominated by its timbered market hall, where Charltons once gathered, there worked a great family doctor, to whom I owe my delivery and rest to become a doctor. To him, general practice was a life to be lived and not just a job to be done. It may have been the variety of vintage cars, peculiar shaped pipes, and trillies that first fascinated a younger man, but his reading was not limited to the car and the pipe. Our village house a spotless tiny branch surgery in a cottage in the shadow of the church and the school, next to the communal bake-house. The doctor, a founder member and one-time president of the London Welsh Rugby Football Club, was a great, compassionate, complete physician and obstetrician, and kept up to date with medicine by reading the journals and attending evening surgeries. In those days the answering service was a devoted wife, and deputising services had not been invented.

One day he said to me "Bill, there's something I must tell you, believe it or not." "There dwelt in a tiny hamlet near two spinsters, sisters, "Mary" and "Martha." They eked out a very modest existence on a small holding, thanks to a "brandy" Macfarlane's brew. Time came when Mary had to be admitted to the local war memorial hospital, suffering from visible multiple secondary carcinoma of the test wall. Our beloved doctor, who had been a great help to Mary's rescue. One day he burst into the ward and blurted out to Mary that Martha, at home, was stricken by an acute and serious ailment, and little Mary and his creatures had no one to care for them. The shocked Mary reacted by demanding her immediate discharge home. When she was seen about two weeks later there was no trace of cancer. Our doctor's son did poorly medical work with the Ekinses, after serving in the RAMC in the Far East, with the rank of brigadier, which warranted a glowing obituary in *The Times* a few years ago.

THE UNCONSCIOUS CHILD

The child who is in a coma should be admitted to hospital, but an initial assessment at home is essential, as a child unconscious because of hypoglycaemia requires immediate treatment to prevent brain damage. This should be started in the home either with intravenous dextrose or intramuscular glucose. In coma due to septicaemia 200 mg hydrocortisone should be given intravenously and immediate admission to hospital arranged. Other causes of unconsciousness in children include drug overdose, neurological problems, metabolic diseases including diabetes, and head injury. All will need admission to hospital.

Conclusion

Managing emergencies in children may be an exciting and rewarding experience for the family doctor. A much neglected aspect of paediatrics appears to be preventive medicine. After all the family doctor has a unique opportunity to advise parents about so many hazards, and this could help reduce the appalling number of unnecessary accidents in the home.

I thank Dr Nansi Phillips, SCMO (child health), for her advice and Miss P Browne for typing this manuscript.

His delightful daughter has produced doctors, one of whom does reconstructive surgery. Over 50 years ago the old doctor announced my brother with "rag and bottle" to that a general practitioner/surgeon, who drove over Plymouth in the night from the Cardiganhire coast, could remove his perforating appendix on my father's study table. If you climb the hill behind our house and look as far as you can see in every direction you will be scanning the extent of the old practice. Should you by chance spy a fast moving small car weaving its way to some remote farmstead, it could be the ever youthful doctor of the same surname, whose bold head was once capped for Wales, and who still carries on after more than 80 summers in the great tradition—my mentor and friend.

Were these years like the cars—vintage? Yes, I believe it.—G MURRAY JONES, general practitioner, Caerphilly.

First manned flight of the "BMJ"

All living things are creatures of habit—even doctors. Since I left the Royal Navy, almost 35 years ago, I have read the *British Medical Journal* on Sunday evenings and marked on the front page interesting items. The electrician facilitated instant learning the following day—during the spare moments of traffic jams or between consultations. Therefore the *BMJ* has always spent the night of Sunday on the staircase so that it will not be overlooked during the 8 am rush on Monday.

Six weeks after a laparotomy and on the day I returned to work, my habit had reasserted itself. Regrettably, the combination of unfamiliarity, haste, and blotted lenses caused me to overlook the *Journal* lurking on the carpeted staircase, down which I literally fell. My dog's astonishment at my fall from grace was rapidly justified at hospital. The human foot encounter, at the present time, a much smoother and shinier *Journal* than that of 30 years ago—when an article of mine was published, preserved, cherished, and now recently tested as a method of travel. Experiments on a pre-recorded tape distinguished between the human foot and the dog's paw. The tape proved that the coefficient of friction was much higher than now. The *Journal* therefore has become a "slipper." But my booby skeleton bears it no grudge. No experience is entirely bad. For example, I have learned that broken ribs are somewhat painful and that to be horizontal, without assistance at hand, is quite uncomfortable. I continue to read the *British Medical Journal* on Sunday evenings, but the carpet connection of former severity.—DAVID G. ELLIOTT-WORTH, general practitioner, Edinburgh.

We will be pleased to consider for publication other interesting stories from general practice.—Ed, BMJ.