

Letters

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Child neglect

The editorial '*Child neglect: what does it have to do with general practice?*'¹ refers to the RCGP's '*Grasping the nettle*' report 2004² that has been formative in developing RCGP guidance. This report mentions the still thorny issue of compulsion in the context of sharing information on a child or family about whom we have concerns, and the unresolved issue of whether we should require all children to have a 'new patient medical'.

It was followed by the '*Keep me safe strategy for child protection*'³ in 2005 that set out to examine child protection as it relates to general practice, and proposed a unified and consistent approach to safeguarding issues, where neglect often goes with other forms of abuse, and can be recognised by GPs who have known the community and families for years. Neglect goes from generation to generation.

The RCGP was proactive in seeking partnership with the National Society for Prevention of Cruelty to Children (NSPCC) in writing a collection of comprehensive and coherent educational tools that could be disseminated to all GPs for use in practice training and development to help resolve these issues. The Safeguarding Children and Young People Toolkit (2007, updated 2009⁴) was born out of this vision.

The RCGP responded in writing⁵ to Lord Laming's report after Baby Peter's death, and has gone on to appoint a Child Health Clinical Champion 2010–2012. Far from neglecting the neglected, the champion has a mandate to form a strategy to prioritise those children most in need and enable GPs to give appropriate support.

Within the RCGP, the Primary Care Child Safeguarding Forum (PCCSF) works to encourage and resource GPs in all aspects of child safeguarding including neglect. We stand with the College's vision.

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REFERENCES

1. Wilson P. Child neglect: what does it have to do with general practice? *Br J Gen Pract* 2009; **60**(570): 5–7.
2. Royal College of General Practitioners. *Grasping the nettle: the GP, the child and information sharing*. Report from the workshop held on 27 January 2004, sections 27/28. www.rcgp.org.uk/PDF/Corp_grasping_the_nettle.pdf (accessed 11 Jan 2010).
3. Royal College of General Practitioners. '*Keep me safe*'. *The Royal College of General Practitioners strategy for child protection*. www.rcgp.org.uk/PDF/Corp_childprotectionstrategy.pdf (accessed 11 Jan 2010).
4. Royal College of General Practitioners. *Safeguarding children and young people a toolkit for general practice 2009*. http://www.rcgp.org.uk/clinical_and_research/circ/safeguarding_children_toolkit.aspx (accessed 11 Jan 2010).
5. Royal College of General Practitioners. *Chair responds to Lord Laming's report on child protection*. http://www.rcgp.org.uk/news_and_events/news_room/rcgp_news_stories/lord_laming_child_protection_r.aspx (accessed 11 Jan 2010).

DOI: 10.3399/bjgp10X483184

Suicide in later life

The interesting and timely analysis from Pearson and colleagues in the November 2009 issue¹ confirms the richness of the data in the National Confidential Inquiry into homicide and suicide by people with mental illness. The troubling suggestion that people considering suicide may attend their GP for a consultation but still continue to take their own life is not new. This teams' finding that many GPs (following the suicide of a patient) thought

that the death had probably been unavoidable is new, and challenges those who think that the recent decline in suicide rates is attributable to greater primary care skills and confidence. It was not surprising to read that risk assessment needs to be refined and that communication between primary and secondary mental health services could be improved.

We suggest that these are not the only tasks. Pearson *et al*'s findings are that 65 of the 247 patients whose cases they reviewed in the northwest of England were aged 57 years and over, that confirms the importance of investigating suicide in later life (60 were aged under 30 years). There remain few studies of suicide prevention for older people, yet they attend primary care more often than other age groups and so offer more opportunities to identify concerns. Most studies of communication between primary care and mental health services relate to services for adults of working age. Current targets in dementia services may further reduce interest in services for older people with depression, a higher risk group for suicide than the general population of older adults.

This is an age group where communication with social care services is important because they are more likely than specialist mental health teams to know the older person well, through their provision of services related to disability or long-term conditions. GPs have much to contribute to social care assessments, support plans, and risk assessments because of their knowledge of individual patients and their risk factors. Care management by social workers or nurse-led case management can benefit from clinical input to interpret any deterioration in mental health and decide on thresholds for action.

Finally, we sensed some concerns among the GPs interviewed that the unexpectedness of the suicide of a patient may not be acknowledged by others, and that they will be blamed for their failure to prevent it. Support should be available to practitioners working with people who are at risk of suicide, and to those whose patient has taken their own life. This is good for the individual clinician and it can also assist them practically because they are likely to be the people to whom families turn at this time. Death by suicide is often deeply disturbing for those left behind and one contribution a GP can make is to offer personal support and to put the bereaved in touch with suicide bereavement networks.

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REFERENCE

1. Pearson A, Saini P, Da Cruz D, *et al.* Primary care contract prior to suicide in individuals with mental illness. *Br J Gen Pract* 2009; **59**(568): 825–832.

DOI: 10.3399/bjgp10X483193

Author's response

Professors Manthorpe and Iliffe raise some important points regarding suicide prevention for older people and the provision of support that I and my colleagues agree with. For example the authors comment that support should be available to practitioners working with patients at risk and where patients have died by suicide. While we did not discuss this in our paper we did find that two-thirds of GPs reported being affected by the suicide of a patient, but that there was a lack of formal support systems available. Service provision and suicide

prevention in the old is certainly an area that would benefit from further research.

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DOI: 10.3399/bjgp10X483201

Why do we practice CPR?

'Like most GPs and practice nurses,' writes Peter Toon (*'Do we spend too much time with Nellie the Elephant?'*),¹ 'I do (my basic-life support update) every year, because there are four QOF points attached to having all clinical staff trained in basic life support within the last 18 months.' He then puts forward a rather reluctant argument demonstrating the cost-effectiveness of training in cardiopulmonary resuscitation (CPR); reluctant, because he has never encountered a cardiac arrest in the GP surgery in a quarter of a century, nor has anybody else ever told him of such an encounter.

This surprised me. At my own last CPR update the facilitator asked who had been present at a cardiac arrest in the past 6 months and there was a show of hands. I myself have carried out bystander CPR in the street three times so far during my career, when I haven't even been at work. As for its cost-effectiveness, the three episodes all occurred overseas and I didn't charge for my services so the relevant health boards literally didn't pay a penny. Two of the three patients survived; the third had suffered a blunt trauma arrest in a road crash so the outlook was always bleak.

But it seems to me that Peter Toon reaches the right conclusion for the wrong reasons. The effectiveness of CPR training extends far beyond the context of cardiac arrest. Cardiac arrest is the archetype for all extreme medical emergencies, the ultimate exemplar of the great triad of physiological decompensation — respiratory embarrassment, shock, and

diminished consciousness. CPR training is as much a thought experiment as a practical rehearsal. What would I do if my patient suddenly collapsed?

Well, I would take a moment to look at the situation and think, what am I about to get myself into? Then I would approach the patient and check for airway, breathing, circulation, and neurological disability. I would also try and get a handle on what was going on, pathophysiologically. For example, if the patient's ECG trace showed pulseless electrical activity (PEA) I would want the differential diagnosis of PEA to be at the front of my head. Imagine if your patient had a tension pneumothorax and you hadn't rehearsed how to recognise this condition, and the simple temporising intervention that could save a life, for the cost of a Venflon.

I would also want to have a notion of the ethics of resuscitation. GPs looking after their own patients are uniquely placed to evaluate whether the decision to embark on CPR will respect the patient's autonomy, will be beneficent, will be non-maleficent, and will be just.

The cardiac arrest scenario is a pure distillation of every medical emergency because airway, breathing, circulation, and consciousness are all absent and need to be restored in a precise order. Therefore, the approach to the arrest is a simplification of the approach to any other emergency. And if you cannot manage a cardiac arrest, then there is no way you can manage an upper airway obstruction, acute severe asthma, anaphylaxis, septicaemia shock, hypoglycaemic coma, status epilepticus ...

But more than that; not only does confidence in CPR inform our approach to any aspect of emergency medicine, it informs literally every consultation we undertake. We all like to think we have a 'sixth sense' for the patient in the waiting room who is ill, who is decompensating. But it is not a sixth sense, it is an acquired skill, the application of the principles of emergency medicine to every encounter. We watch the patient coming into the consulting room from the waiting room and think, 'Am I safe? Is the patient safe? Is the airway patent, the breathing