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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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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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