

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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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?'*),<sup>1</sup> '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

normal? Pink and well perfused? Glasgow Coma Scale 15?' In a word, we practise triage, constantly.

That is why we practise CPR. Forget the QOF.

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DOI: 10.3399/bjgp10X483210

## Salaried doctors

As a former senior partner of 20 years and a salaried doctor of 4 years, the conclusions of this rather interesting piece of research are no surprise. We are left with the overall impression of smug partners and embittered salaried GPs. My sympathies tend to be with the latter.

I know that my following plea is likely to fall on deaf ears, but I think it is worth making nevertheless. That is for those partners who are perhaps half a decade, or even a decade, away from retirement to make the brave step of changing directions. Perhaps it is time to voluntarily step down to a salaried position? Why not act as a grandparent to our younger colleagues? You know what I mean. To be happy to hold the baby while your sons/daughters are out shopping, but to be even happier handing him/her back at the end of the day for them to go through those sleepless nights. We are still there for advice, and are still going to be paid more than the vast majority of people in this country. We still have our savings, our paid-for house, our comfortable living. And now perhaps a chance to expand to do what we always wanted to do — hobbies or another field of medicine. What are you waiting for?

I know this because I did it. I have never regretted for a second that I left my well-established and increasingly successful practice. I enjoy watching it expand and I am pretty sure that I would

have held it back if I had remained. We are still on friendly terms, and perhaps I retain a bit of a feeling that I had some part in its creation ... but it now needs to grow-up. Meanwhile, I am learning and working in other areas of medicine that I never really knew existed, and meeting others in related professions whom I continue to learn from. This would never have happened had I stayed.

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DOI: 10.3399/bjgp10X483229

## STIs in general practice

Sacks and Goodburn discuss increasing HIV-testing in general practice.<sup>1</sup> Improved uptake of HIV-testing is important since the Health Protection Agency estimate that 21 000 people are living with undiagnosed HIV in the UK.<sup>2</sup> Women attending antenatal clinics are already tested for HIV routinely, but little is known about the feasibility of testing male partners. Following ethical review (Wandsworth Research Ethics Committee Reference: 00167.09) we conducted a questionnaire survey to investigate the attitudes of pregnant women to having their partners tested for HIV.

In December 2009, a confidential questionnaire was handed out by a medical student (TS) to consecutive pregnant women attending the antenatal clinic at St. George's Hospital, London.

The response rate was 93% (100/108). The mean age of responders was 30 years (range 20–45 years). Fifty-eight per cent of women described their ethnic group as white, 18% as black, 18% as South Asian, and 6% as other ethnic group. Most women (83%) thought it was a good idea for their partner to have a salivary test to check for HIV, while 82% thought it was a good idea to have a blood test. They identified the main benefits of testing their partners: to ensure

the safety of the mother and baby, and for peace of mind. They saw less benefit if their partner had recently been tested or the mother had already tested negative. The myth that one partner testing negative means that the other does not need to be tested was identified in our earlier study of male partners who cited the same reason for not testing.<sup>3</sup>

However, many women wanted to know how HIV-testing could help their baby, and appeared to be unaware of effective treatments to prevent transmission of infection. Increased knowledge about HIV has been shown to be associated with increased test uptake by pregnant women.<sup>4</sup> Sacks and Goodburn suggest little pre-test counselling is needed unless a patient is high-risk,<sup>1</sup> and most pregnant women in our study were happy for their partner to be tested for HIV. However, GPs and other health professionals could have a crucial role in encouraging uptake of HIV-testing by educating patients about the benefits of early diagnosis and treatment of HIV.

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#### Acknowledgements

We would like to thank the patients and staff at the antenatal clinic at St. George's Hospital, London, SW17.

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