employment as well as causing discontent by arrest of promotion. Finally, superfluous staff can be dismissed with an obligatory increase in the unemployed.

A more penetrating analysis suggests therefore that many of the measures described by your special correspondent would help the Health Service finances only by tipping over expenses to other governmental or private organisations and would have little effect, if any, on the total national economy.

How then can money be saved? As I see it there are two methods which would give a considerable saving. The first is to reallocate available resources to departments which are economically essential—for example, rehabilitation aiming at a return to employment—from those which are not—for example, geriatric medicine. Such methods may be socially unacceptable if carried to extremes and politicians will find the tightrope they have to walk may have a noose at the end. The second method is to restrict sick pay for those in hospital, the portion withheld from both National Health and private insurances being paid to the hospital authorities. This would save money, encourage patients to accept early discharge, and perhaps give meaningful employment by its administration and collection to the maligned unproductive civil servants.

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Hypercalcaemia after tamoxifen for breast cancer

SIR,—The suggestion that hypercalcaemia after tamoxifen may be a sign of breast cancer response is unwarranted on the evidence produced by Dr A H Villalon and others (24 November, p 1329).

Only one of the four patients (case 1) definitely showed a response to tamoxifen alone, and two patients (cases 2 and 3) exhibited very unimpressive rises in serum calcium concentration. Such slight rises are commonly seen as part of a temporal variation in patients with a tendency to hypercalcaemia, in which rises and falls occur in response to homoeostatic mechanisms and degree of hydration. At least one patient (case 1) had preceding vomiting which, through dehydration, may itself have precipitated hypercalcaemia. Case 4, in addition to tamoxifen, received combination chemotherapy, and the latter may have been responsible for the tumour response, let alone dehydration through nausea or vomiting.

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Resuscitation of the newborn

SIR,—Dr H B Valman's article on neonatal resuscitation (24 November, p 1343) was interesting and his emphasis on effective ventilation rather than medication with bicarbonate and other drugs is important.

I am, however, disturbed that he advocates ventilation using a Penlon bag via an endotracheal tube. The Penlon bag was designed for use with a face mask and, although it has pressure-limiting valves, when used with a mask it has the additional safety valve of oesophageal opening with pressure peaks. Dr Valman rightly stresses that pressures in excess of 30 mm of water should not be used on an endotracheal tube, but the Penlon bag can easily exceed these pressures with enthusiastic squeezing. This can be readily demonstrated by connecting the Penlon bag to a sphygmomanometer, when pressures of 100 mm of mercury can be reached with ease. At these pressures (equivalent to 135·5 cm of water) the danger of pneumothorax is obvious.

I would suggest that it is hazardous to use this device on an endotracheal tube. An alternative form in use in the Vickers Resuscitaire is more suitable. A lift-off relief valve and aneroid pressure barometer is a simple and safer alternative and is the principle used in some designs of neonatal ventilator.

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SIR,—May I offer a few comments on resuscitation of the newborn (24 November, p 1343)?

There should be much more emphasis on the use of a facepiece *and* oropharyngeal airway for positive-pressure ventilation with oxygen in the first instance. Most of the time this will be all that is needed to oxygenate the baby and start normal respiration. Oxygen is vital, not just useful. One breath of oxygen is worth five breaths of air in this situation.

The size of endotracheal tube should be 3·5 mm at the least, unless the baby is excessively premature. It should not then be possible to pass the tube right through the larynx with the attendant risk of intubating one bronchus. A tube of less than the proper size can cause almost total respiratory obstruction, and if a suction catheter is inserted into the tube there is great risk of sucking the baby's lungs flat. Incidentally, the illustrations showing an endotracheal tube in position in the larynx are seriously misleading, as the scale is quite inaccurate, though the appearance of the glottis as seen from above is well shown.

My experience of obstetric anaesthesia over many years suggests that, with modern obstetric care and modern anaesthesia, intubation of the newborn is not very often needed—perhaps one case in five, or less. And the risk of the inexpert intubating the oesophagus, and not recognising the fact, is considerable and often fatal. Midwives can easily learn positive-pressure ventilation by facepiece and airway, and so avoid the need for more skilled and hazardous methods in most cases.

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Accident and emergency services

SIR,—As one of the first senior registrars appointed in accident and emergency in Great Britain, I would like to comment on the article "How should accident and emergency departments be run?" (27 October, p 1051). As your special correspondent rightly pointed out, controversy continues about who should run accident departments, and how far the emergency care of the patient should be under the control of the accident consultant or handed over to his specialist colleagues.

Having obtained a suitable postgraduate qualification (in my case a surgical fellowship) and now completed three years as a senior registrar in accident and emergency, I am amazed how anyone who has not completed at least this amount of specialist training can contemplate taking up a consultant post in accident and emergency. The reasons for having a specialist consultant are to my mind straightforward. It is mainly that with his varied clinical experience he will be able to deal with any problems his junior staff have with the diagnosis and management of patients. This will occasionally save a patient's life, and almost certainly save patients inconvenience and possible complaints against the hospital. The importance of making the correct diagnosis in the accident situation cannot be overstressed with the general public becoming increasingly litigation conscious. How can anyone who has not worked in an accident department at the senior registrar level and, more important, rotated through various specialised subjects have the confidence that he will be able to do this? And yet, as your article points out, it is hoped to appoint 250 accident consultants, but to consider asking for a maximum of 30 senior registrars. Where are the remaining consultants to come from?

My fear is that they will be made up by appointing registrars and senior registrars who, for one reason or another, have not made the grade in their own specialties. If this occurs it will be a disaster for the accident service in Great Britain. The current advantage of the senior registrar training programme is that one is required to rotate to specialist units and one is able to see only too well the problems of diagnosis and referral that occur. Just as one would not consider appointing a consultant in general surgery or orthopaedics who had not served an adequate time as a senior registrar, so the future accident consultant should be required to complete an adequate senior registrar training.

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Multidisciplinary teams

SIR,—Your leading article "Who carries the can?" (17 November, p 1245) is most welcome. It emphasises the merits of the old hierarchical system of team management, which are still absolutely fundamental to good medical practice. It refers to Drs James Appleyard and J G Maden's criticisms (p 1305) of multidisciplinary teams, as constituted in adult and child psychiatry. Their statement that the multidisciplinary system has eroded clinical care in geriatric medicine may be applicable in England; but it certainly does not apply in Scotland.

Here in Tayside (where the first consultant in geriatric medicine in Scotland was appointed in 1951 and where the first university department of geriatrics in Britain was created in 1961 within St Andrews University) the system of weekly ward case conferences working as a multidisciplinary co-ordinated team, whose leader is the consultant in geriatric medicine, has been in constant use in both Dundee and Angus districts for nearly a quarter of a century. Our system has been