immunisation. This difference was significant ($p = <0{\cdot}005$, χ^2 analysis). While it is assumed that half of those women might have a live birth after numerous additional abortions, these abortions may be prevented by immunotherapy. Moreover, women who have had one spontaneous abortion who have their immune response altered by immunotherapy seem to have second subsequently successful pregnancies. (This has occurred in all five patients who have become pregnant a second time in our series.) Though such women have spontaneously successful pregnancies, however, they seem to revert to their tendency to abort afterwards. Nine patients in our series had two or more abortions after a spontaneously successful pregnancy. Only one patient had two subsequently successful pregnancies after one spontaneous abortion.

We therefore consider immunotherapy to be a most effective form of treatment for women who have had missed abortions, and the results of Drs Vlaanderen and Treffers do not convince us otherwise.

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1 Ornoy A, Salomon J, Ben Zur Z, Kohn G. Placental findings in spontaneous abortions and stillbirths. *Teratology* 1981;21:243-52.
2 Kardon NB, Davis JG, Berger A, Broekman A. Incidence of chromosomal rearrangement in couples with reproductive loss. *Hum Genet* 1980;53:161-4.
3 Mowbray JF, Gibbings CR, Underwood JL, Liddel H, Reginald RW, Beard RW. Controlled trial of treatment of recurrent spontaneous abortions by immunisation with paternal cells. *Lancet* 1985;i:941-3.

Emotional distress in junior doctors

Sir,—Ms Jenny Firth-Cozens (29 August, p 533) suggests that problems of stress in clinical work should be dealt with in the undergraduate medical curriculum.[1] I agree, but I would add that we still have much to learn about the most appropriate way of doing this.

Some preliminary observations from Bristol's new undergraduate management teaching may be of interest. This forms part of our clinical community medicine course in the fourth year and is perhaps an example of the "innovative approach to management education" being sought by the National Health Service Training Authority.[2] Doctors are an expensive commodity; it makes good sense to help them to maintain and maximise their performance in delivering health care.

The focus of our approach is the clinical ward team, as experienced by house officers. Through this teaching I have become aware of the mismatch between our medical training, which encourages extreme competitiveness between individuals, and the requirements of good medical care, which demands a high level of teamwork. As a corollary, the type of training that we provide may inhibit rather than encourage many students from seeking support when under stress. In a series of voluntary workshops on "Coping with the demands of becoming a doctor: stress and satisfaction" students have been surprised to discover that most of their peers are also experiencing feelings of inadequacy and uncertainty about the nature of their task. They are often relieved to find that they are not, after all, peculiar. Students also speak of the scarcity of opportunities in the medical course for admitting such emotions.

As part of the core teaching on teamwork senior nursing and medical students examine potential areas of cooperation and conflict between house officers and staff nurses. This has shown considerable misunderstanding and negative feelings between the two groups, with examples of how such feelings may increase the stress on all concerned. For instance, doctors who fail to communicate adequately with the nursing staff about patient care or are insensitive to the pressures of nurses' work routines increase their risk of being woken at night.

Evaluation of this and our other teaching on teamwork shows that it is popular and there is demand for more. As a result of these workshops, students have developed together some positive "action plans," describing what they would like to do, as staff nurses and house officers, to improve working relationships and provide each other with more support. It is too soon, however, to determine whether this results in changed behaviour. We would be interested to hear from others who are exploring these issues at the undergraduate and house officer levels.

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1 Firth J. Levels and sources of stress in medical students. *Br Med J* 1986;292:1177-80.
2 National Health Service Training Authority. *Developing the role of doctors in the management of the National Health Service. A discussion document.* London: NTA, 1986:23.

Sir,—The paper by Ms Jenny Firth-Cozens on emotional distress in junior house officers (29 August, p 533) is important and will, we hope, not go unnoticed either by consultants or by employing authorities. A similar but less detailed study was undertaken in the South Western region three years ago (precipitated by the suicide of a junior doctor) and produced similar results. Without any financial incentive, the rate of response to our questionnaire was only 38%, but this nevertheless produced 397 responses. There was a high incidence of crises related to workload, the stress of the job, and worries about career prospects.

Many replies showed considerable cynicism and bitterness about the medical establishment and the lack of sympathy with the problems of sheer overwork experienced by junior doctors. Many thought that the present system of obtaining help was unsatisfactory.

Our reaction to our studies was to encourage each district to set up a counselling system for junior doctors, either within their own specialty through tutors and regional advisers or, if the problem was not specialty based, through the general practice clinical tutor, with the regional postgraduate dean's office being available to all. We emphasised that these services should be adequately advertised and freely available. It also became clear that many junior doctors, because of their frequent changes of place of employment, never registered with a general practitioner, and we have requested that employing authorities make this a condition of employment so that, in common with the rest of the community, junior doctors at least have the basic important support of a family doctor.

Most of the other points made by Ms Firth-Cozens were echoed by our own studies. We believe that the problem is considerable and one that should be seen as a major responsibility for a caring profession.

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Is the tube in the trachea?

Sir,—Over the past few weeks I have been looking into various methods used to place endotracheal tubes and cuffs in the trachea correctly and confirm their positions. Drs Peter A Coe and R M Towey (19 September, p 723) rightly point out that the most reliable method available to check the position of a tube after non-visualised, difficult intubation is with an intubating fibrescope. Though this test is simple and extremely easy to perform, I would disagree with them that no previous experience is needed to identify the mucous membrane overlying the tracheal rings and the carina from the mucous membrane of the oesophagus. I would therefore suggest that during their training anaesthetists should routinely use a fibreoptic bronchoscope through the endotracheal tube so that they learn to recognise the tracheal rings and the carina.

A new process has been developed, based on the transcutaneous detection of a specially designed tracheal tube that contains a magnetic marker (Track Mate intubation system, McCormick Laboratories Inc). The sensing probe transcutaneously detects the position of the magnetic marker by producing light and sound signals, the intensity of which correlates with the proximity of the tube marker to the probe.

Patients do not die from "failure to intubate."[1] They die from failure to stop trying to intubate or from undiagnosed oesophageal intubation. It is therefore important to remove the tube and ventilate the patient with a mask when there is doubt about the correct placement of the tube associated with clinical deterioration.

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1 Scott DB. Endotracheal intubation: friend or foe. *Br Med J* 1986;292:157-8.

Sir,—While direct visualisation of the trachea through a flexible endoscope passed through the tube as suggested by Drs P A Coe and R M Towey (19 September, p 723), seems attractive, we would caution against its routine use because we believe that corners will be cut when the instrument requires sterilisation. Sterilisation requires at least 30 minutes' immersion in 2% gluteraldehyde solution,[1] and more than one bronchoscope for each theatre suite will almost certainly be required, making this a potentially expensive exercise.

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1 Department of Health and Social Security. *Decontamination of equipment, linen or other surfaces contaminated with hepatitis B or human immunodeficiency virus.* London: HMSO, 1987. (Health Notice HN(87)1.)

Acyclovir for shingles

Sir,—The Wellcome Foundation Ltd advertises a course of acyclovir for shingles at a basic cost of £119.

Nobody doubts the need to treat a high risk attack—for example, ophthalmic shingles or the Ramsey-Hunt syndrome—with all possible means, but surely it is misleading to imply that we should use it for every attack.

Of the 80 patients presenting to me with shingles in general practice over nine years, 25 were aged less than 50, and none of these were suffering from a severe attack. All that was needed was reassur-