intensive help that these families need.

Finally, I would question Dr. Hersov's suggestion that the family doctor is in a position to provide the necessary help. Apart from the shortage of time which must surely prevent him from carrying out the necessary interviews with all the family, including the father, I would feel that his medical training does not equip him with the necessary knowledge and skills to help the family solve its social problems. I do, however, feel that the family doctor is an important source of referral in such cases and liaison between doctor and social worker is necessary particularly if any form of medical treatment is required.—I am, etc.,

(Mrs.) DIANA J. LEIGH
Senior Social Worker

Northumberland Social Service Dept.

Cardiac Responses to Thermal, Physical, and Emotional Stress

SIR,—Owing to an oversight, the following section was omitted from our paper (8 July, p. 71)

"We wish to thank Dr. Walter Somerville and Professor Norman Ashton for their help and criticism in the preparation of this article; Mr. Alistair Murray for practical assistance and interest at the City Gymnasium; Dr. P. G. Nixon for permission to study his patients; Dr. C. G. Hunter for the kind loan of a rowing ergometer; Professor J. W. Stewart of the Bland Sutton Institute of Pathology, Mr. F. R. A. Yeomans of the Courtauld Institute of Biochemistry, and Miss Eileen Willmott of the Institute of Ophthalmology, for their assistance; Nordic Sauna Ltd. for supplying background information.—We are, etc.,

PETER TAGGART
PETER PARKINSON
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Institute of Ophthalmology,
London W.C.1

Misplaced Endotracheal Tube in Newborn

SIR,—Endotracheal intubation in the resuscitation of the newborn baby is not always devoid of complications, and the following case is a reminder of one of the rarer ones.

Recently a newborn baby boy weighing 3 kg was transferred to this hospital with a misplaced endotracheal tube. After birth the baby was slow to breathe, and because of poor respiratory efforts an attempt was made to resuscitate him by endotracheal intubation. Unfortunately the tube was accidentally passed into the oesophagus and lost. Satisfactory respiration was established despite this. The lost tube was removed under general anaesthesia, using an infant-size oesophagoscope. The postoperative recovery was uneventful.

Fortunately this is an uncommon accident, since it can produce complications. The newborn baby who needs resuscitation has to be submitted to a general anaesthetic for removal of the tube. The transfer of the infant to a hospital equipped to deal with neonatal emergencies may be necessary, as attempts at removal of the tube without the infant-sized oesophagoscope may cause damage to the pharynx and larynx and lead to further complications.¹

It is conceivable that the distal end of the tube, which is against the greater curvature

of the stomach, may perforate it.² The utmost care has to be exercised while removing the tube as pressure from the oesophagoscope at the proximal end of the tube may push the distal end through the wall of the stomach.

The length of endotracheal tube used in this instance was clearly excessive, and a shorter one eliminates the risk of endobronchial intubation. The accident is avoidable as the tube should never be passed without the connector attached to it. A plastic tail as suggested by Dickson *et al.*,¹ or incorporation of a thread in the wall of the tube to facilitate withdrawal, are alternatives to the use of a connector.

I am indebted to Mr. R. Pracy and Dr. G. Jackson Rees for encouragement and permission to report this case.

—I am, etc.,

Y. N. PANDE

Alder Hey Children's Hospital, Liverpool

- ¹ Dickson, J. A. S., and Fraser, G., *British Medical Journal*, 1967, 2, 811.
- ² Wilkinson, A. W., *British Medical Journal*, 1965, 1, 838.

General-practitioner Hospitals

SIR,—The development of community hospitals which seems imminent gives urgency to the need for free and open discussion of the future of over 100 general-practitioner maternity hospitals in England and Wales. Wholesale closures as envisaged in the Peel Report¹ will not merely mean the loss of local facilities and of the well-developed skills of local practitioners but will have repercussions on the obstetric side of the medical curriculum and the staffing of specialist units. Shall active obstetrics remain a natural part of general practice? Or should we steer towards a new breed of specialist concerned solely with obstetrics and neonatal life?

There are strong arguments for concentration on centralized units. These are based on the occurrence of unpredicted obstetric emergencies calling for immediate access to special skills and equipment. In cities and some suburban areas the physical integration of general practitioner and consultant beds has gone far towards solving this problem, but only at the expense of depriving many keen general practitioner obstetricians of that ease of access which is so vital to the proper conduct of labour.

In many areas problems of location, logistics, and staffing make total concentration of obstetric beds impossible. There are also (in our experience) many women who would prefer to be confined in a small hospital near their homes provided that authoritative assurance can be given that in any particular case the obstetric risks are minimal.

By careful selection, employing the criteria of the Royal College of Obstetricians and Gynaecologists and in close collaboration with consultant colleagues, the general practitioners staffing peripheral units in the Oxford region have recently achieved a perinatal mortality rate of nil. These remarkable results may seem immediately to justify the retention of the units, but the Royal College of Obstetricians and Gynaecologists rightly raises the question of the mortality rate in transferred cases which some of their members claim to be unjustifiably high. The point is of greatest importance. To prove or disprove this claim would require a well planned study of two exact-

ly comparable areas, one of which follows the "Oxford" pattern and the other pursues a policy of total concentration. Unfortunately, it seems that such a study would be virtually impossible owing to the number of variables involved.

Nevertheless, on the best evidence available, it would seem fair to say that when the first baby has been born normally and when no adverse factors have developed in the pregnancy (and assuming good antenatal care) the risk of perinatal asphyxia and loss to para 2-4 mothers in the 20-30 age group will be of the order of one per thousand deliveries. The committee of the Association of General Practitioner Hospitals feels that it is at any rate possible that some mothers may feel this risk worth taking to secure the advantages of delivery nearer home, by persons known to them, and who have attended them antenatally.

The committee has listened in private to the views of a number of distinguished obstetricians, paediatricians, and general practitioners. Some of their views proved to be diametrically opposed. The committee therefore feels that there is a need for open debate on this important subject. The evidence revealed may make more certain that the final decisions reached are the right ones.—I am, etc.,

R. M. EMRYS-ROBERTS,
Chairman,

Association of General Practitioner Hospitals

Walton-on-Thames, Surrey

- ¹ Department of Health and Social Security. Welsh Office. Central Health Services Council. Standing Maternity and Midwifery Advisory Committee. *Domiciliary Midwifery and Maternity Bed Needs*. Report of the Subcommittee. London, H.M.S.O. 1970.

Future of Postgraduate Medical Centres

SIR,—We have followed, with interest, the correspondence which has followed the publication of our letter and your leading article (3 June, pp. 589 and 547 respectively).

We wish to correct any misconception that clinical tutors are not willing to collaborate with disciplines other than medicine in the educational activities of the postgraduate centres. Indeed, they are already doing so and in particular the dental profession is making increasing use of the facilities available and in the majority of centres the premises are freely available for the use of related professions when not required by the doctors themselves.

The concern of the tutors has been that in any new type of hospital education centre the accommodation for the postgraduate medical centre should be adequate, easily identifiable, and remain in the hands of the doctors. Misunderstandings may have arisen owing to inadequate consultation with the profession but it is hoped that a proposed conference between all those concerned with the planning and work of postgraduate centres, which is being arranged by the Council for Postgraduate Medical Education, will ensure that a satisfactory future pattern will be agreed.—We are, etc.,

JOHN LISTER
Chairman,

Windsor, Berks

DAVID FERRIMAN

Honorary Secretary,
National Association of Clinical Tutors

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