been suggested that the G.P.s need better access to ancillary services, but on present evidence it is doubtful if, even if such help was available, they would be able to make full and proper use of them. If the G.P. is to take on a key role in the community services his training will require considerable reorientation, with much more emphasis on the medical needs of society and on the behavioural sciences.

More direct consultation of G.P.s by the local health authority may make them feel more active participants rather than passive consumers of services. The trend towards group general practice should favour the introduction of local authority ancillary staff and help to improve integration with social and welfare services. Experiments on these lines are already in operation, but not so far on a scale which allows proper assessment of their value.

Until general practice undergoes a fairly drastic reorganization in its method of training, and in its relation with hospital and local authority services, it is unrealistic to expect that the G.P. can achieve his potential contribution to the management of psychiatric cases in the community.

Summary

This article describes a survey of a randomly selected group of general practitioners in one of the Greater London boroughs. The aim of the study, undertaken in 1963–4, was to get some idea of the G.P.'s attitude towards psychiatry and his willingness to participate in a local mental health service. This has become increasingly important in view of official expectations that the G.P. can be the future leader of social service and nursing personnel working in the community.

Each of the 69 G.P.s interviewed was seen twice. The interviews were based on a structured questionary, with some difference in emphasis between them. The findings suggest that the G.P.'s ability to participate in a local psychiatric service is very limited. Those who had undergone psychiatric postgraduate training seem to be in a position to make a much more positive contribution. At present the G.P.'s concept of his role is one of detachment from the organization and operation of specialist psychiatric services, and until general practice undergoes some reorganization in its methods of training and its relation with hospital and local authority services it is unrealistic to expect any more from it.

We express our thanks to the general practitioners who collaborated in this study for their courtesy and the time they gave for frank discussion. From Miss A. Lane and Mr. G. W. Kalton we obtained valuable advice and assistance on the statistical evaluation; and without the financial support of the South-west Metropolitan Regional Hospital Board this investigation would not have been possible.

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NEW APPLIANCES

Improved Plastic Endotracheal Tubes

Dr. M. K. SYKES, reader in anaesthetics, Royal Postgraduate Medical School, London W.12, writes: Plastic cuffed endotracheal tubes are being used increasingly for maintenance of the airway in an attempt to avoid the hazards associated with tracheostomy. Fixation of these tubes is not easy, and there is a risk of inadvertent intubation of one bronchus if the tube is too long. The position of the tube can be checked on a radiograph. However, it is often difficult to identify the position of the tip of the tube, particularly if the patient is obese or the radiograph is incorrectly exposed. To overcome this difficulty a tube has been designed with a radio-opaque marker placed close to the tip (Fig. 1). The marker is located in the channel in the tube wall which is normally used for inflating the cuff. The lumen of this channel just below the cuff is blocked off with a plastic rod and the marker is then inserted. The marker consists of a ½-in. (1.3-cm.) length of grade 18/8 stainless steel rod. This is held in place by another length of plastic rod, which is also cemented into the tube. The marker is thus situated close to the end of the tube and is clearly visible on the chest radiograph (Fig. 2).

The tube is manufactured by Portex Ltd., Hythe, Kent.

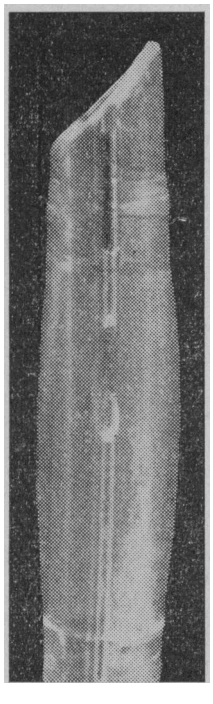

FIG. 1. — Improved plastic endotracheal tube, showing radio-opaque marker.

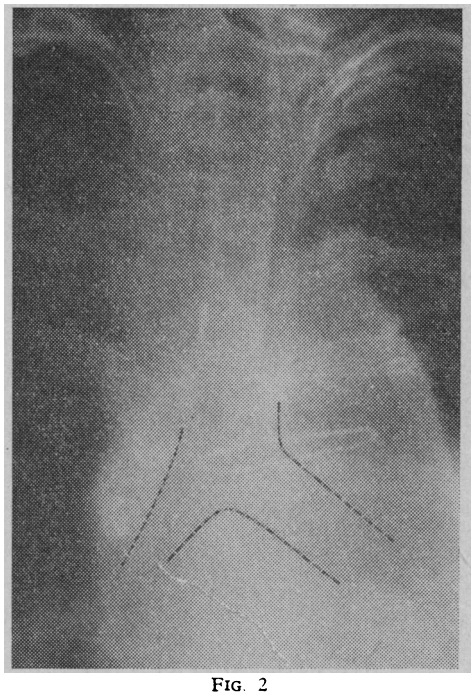

FIG. 2

FIG. 2.—Part of the postoperative chest radiograph showing the endotracheal tube, the marker being situated behind the sternoclavicular joint. The loop shown in the lower part of the radiograph is a wire suture used to unite the sternum. The broken lines indicate the carina and main bronchi.