can then be maintained with average doses and so far I have not found that resistance occurs again.

I would be interested to hear of other people's experience with this type of case. My impression is that it does not seem to be recognised that ECT apparently brings about an alteration in the physiology which makes the condition once more susceptible to treatment with phenothiazines.

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Reviving the hospital necropsy

SIR,—In your leading article (18 June, p 1560) you apparently agree that "post-mortem room technology needs to be updated so that the pathologist is relieved of detailed dissection and his time used for more specialist work."

Of course, assistance in the post-mortem room is essential, but so far as I am concerned the examination consists of detailed dissection and I do not understand how such work can properly be delegated. Needless to say I have seen considerable embarrassment result through neglect of this principle.

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Concentration of thyroxine-binding globulin and the Thyopac-3 test

SIR,—The finding of Dr W A Burr and his colleagues (19 February, p 485) that the Thyopac-3 test appears to give inaccurate results with high serum levels of thyroxine-binding globulin (TBG) are important. A review of recent results obtained in our laboratory suggests that such underestimation of TBG may have produced a number of misleadingly high Thyopac indices in some pregnant patients.

Such false low T3 uptake results could be due to insufficient radioactive T3 in the tube to ensure saturation of the TBG at high serum levels when the recommended 100 μ l of serum is used in the test. To investigate this possibility the T3 uptake test was carried out with varying quantities of serum and the results read from a graph prepared by adding similar volumes of standard serum to Thyopac-3 tubes (the 25- μ l sample result being multiplied by 4 and so on). In addition, the T3 uptake was calculated as recommended by the manufacturer with tubes containing 100 μ l of serum.

Results of T3 uptake tests on four sera are shown in the accompanying table. These

T3 uptake values with different volumes of serum

Sample volume (μ l)	T3 uptake (%)			
	Serum 1	Serum 2	Serum 3	Serum 4
25	108	120	236	96
50	108	128	234	98
75	108	127	*	101
100	107	128	*	101
125	104	*	*	101
Manufacturer's technique (100 μ l)	107	113	140	101

*Count too high to read from graph

results suggest that with a normal T3 uptake reducing the volume has little effect. However, with high levels the reduced volume of serum produced a much higher result. Serum 3 was from a pregnant patient whose original Thyopac index put her in the "thyrotoxic" category, and subsequent review suggested that this may have been a misleading result. The reported results for patient 3 were: serum thyroxine concentration 262 nmol/l (20.4 μ g/100 ml); T3 uptake 140%; Thyopac index 198.

It is hoped to continue investigations along these lines in an attempt to modify the technique of the Thyopac-3 test to produce more meaningful results in patients with high serum TBG.

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Comparison of treatment with fast neutrons and photons

SIR,—In your issue of 25 June, you publish an article by Dr Mary Catterall and her colleagues at the Hammersmith Hospital (p 1642) about the treatment of advanced tumours of the head and neck by fast neutrons and by photons and also a letter from Mr S J Pocock (p 1661) about randomised clinical trials. This juxtaposition prompts me to write to you.

As one who is deeply interested in the evaluation of neutron therapy and the possible necessity for providing such treatment in many centres throughout the country and also as one fully aware of Dr Catterall's expertise and critical attention to detail, I would like to record my concern that some 60% of the control patients (that is, those treated with photons) were not treated by Dr Catterall or at the Hammersmith Hospital and, even more particularly, at the comment that the doses of radiation received by these patients varied widely, with an average dose lower than that in the neutron series.

Would it be possible for Dr Catterall to give a comparison between the 40% of photon-treated patients who received their treatment at the Hammersmith Hospital and either the whole of the neutron-treated patients or a smaller group whose random selection relates them to this group of photon-treated patients? I am afraid that unless such comparison can be made there will remain a doubt as to whether like is being compared with like in her report.

WILLIAM M ROSS

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Prevention and health

SIR,—In common with many if not most doctors I was prepared to give the reorganised National Health Service a fair trial. But already one disastrous consequence has become very apparent to me—there is now no single recognisable spokesman responsible for the health of the local community. The chief task of the former medical officer of health seems to have become diffused in a complicated impersonal institution called the health board. So I do not now hear the MOH's voice nor read his words extolling the virtues and

problems of preventive medicine—and neither does my regional community, which is more important. Few but the old public health diehards would deny that the former local government health departments were too variable in the quantity and quality of service they provided; nor could it be claimed that control of these services by locally elected members meant that priorities were always right. But the mandate was clear—prevention of disease and promotion of health, and at least the medical profession knew where responsibility lay.

I do not expect clear proof that the new organisation is better or worse than the old, but I do demand honest appraisal by the least biased observers. If that appraisal suggests, as my own surely does, that there should be a return to a more clearly identifiable preventive responsibility within—or without—health boards, then I trust those in power will acknowledge the error and promote a new-style medical officer of health.

I M RICHARDSON

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Women in medicine

SIR,—I was amazed by Professor Donald Court's statement (11 June, p 1522) that the economy cannot maintain women doctors only working four to five sessions a week for their whole career. The economy is lucky they are working at all!

It is not politically expedient to employ women—except during a world war, when nursery facilities were the best they have ever been.

It is not an economical proposition for women to work, as their salary at best is only equal to the cost of the necessary nanny and extra car.

It is not socially acceptable to appointment boards to offer a post to a woman if they have male applicants of any nationality competing for the same post.

It achieves nothing to say that the women graduates must fit the present system. It is to be hoped that when 50% of the graduates are women the system will of necessity be redefined to meet their needs.

ANNE J WHITE

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SIR,—The Review Body Report has confirmed my feeling that women doctors are becoming increasingly more important by filling more and more principal posts in general practice. I would like also to point out that the female undergraduate medical intake is approaching 50%.

On qualification many women are married or engaged and thus the prospect of embarking on one year's house jobs plus three further years' enforced vocational training before they can become principals, let alone pregnant, is daunting. The idea of part-time training amounting to six years, to be undertaken within a prescribed time limit, is even harder to contemplate.

How many good women will be lost to general practice when they take refuge in less arduous specialty training programmes—surgery, for example?

BRIDGET RENNIE

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